

DEPRESSION AND SELF-ESTEEM IN ADULT CHILDREN  
OF ALCOHOLICS AND ADULT CHILDREN  
OF DYSFUNCTIONAL FAMILIES

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Master of Arts

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by  
Sue Ann Christensen  
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# DEPRESSION AND SELF-ESTEEM IN ADULT CHILDREN OF ALCOHOLICS AND ADULT CHILDREN OF DYSFUNCTIONAL FAMILIES

An Abstract of a Thesis by  
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## The problem.

The purpose of this study was to assess whether ACAs have specific characteristics or problems directly related to parental alcoholism or whether they are simply a subset of a larger group of adult children from dysfunctional families. It was hypothesized that participants from dysfunctional families would have more depression and less self-esteem than participants from functional families, regardless of parental alcoholism, and that females would have higher levels of depression than males.

## Procedure.

The sample was composed of 201 participants (73 males, 127 females, 1 no gender available) assigned to one of four groups according to parental alcoholism and family functioning.

## Findings.

Adult children of dysfunctional families reported more depression and lower self-esteem than the adult children of functional families, regardless of parental alcoholism, with adult children from dysfunctional families having similar levels of depression and self-esteem. No gender differences were found for depression or self-esteem.

## Conclusions.

The findings of this study indicated that family dysfunction predicted psychological distress (i.e., higher levels of depression and lower self-esteem), regardless of parental alcoholism.

## Recommendations.

It may be more beneficial to focus research efforts on the effects of family functionality, rather than on a particular population (e.g. Adult Children of Alcoholics).



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## CHAPTER I

### INTRODUCTION

The effect of alcoholism on the children of alcoholics is a currently expanding field of research, with the majority of the research into the identification and problems of adult children of alcoholics having taken place within the last decade. Estimates of the number of adult children of alcoholics in the United States range from 22 million (Ackerman, 1987a) to between 28 and 34 million (Black, Bucky, & Wilder-Padilla, 1986).

Ackerman (1987a, p. 1) defined an adult child of an alcoholic as "any adult who, as a child, was reared by one or two alcoholic parents." Woititz (1986) described adult children of alcoholics as having grown up in homes that were filled with inconsistency and uncertainty concerning what it means to be an "adult". For example, the alcoholic parent is functioning as an adult and a parent when the child leaves for school, but is passed out on the floor when the child returns home from school. She hypothesized that if ACAs experience this uncertainty and inconsistency during childhood and adolescence, when they are forming the values and perspectives with which they will function in the adult world, it may shape their adult lives significantly. For these children, there are no clear perspectives of reality, no clear role models, no patterns of appropriate behavior, and no consistent basis for developing self-esteem or respect for others.

Another view of the alcoholic family and its effect on the children in the family was that of Deutsch (1982), who stated that similarities exist within families that have nothing but alcoholism in common and that alcoholic

families are dominated, to varying degrees, by five conditions: the centrality of the alcoholic and alcohol-related behavior; denial and shame; inconsistency, insecurity, and fear; anger and hatred; and guilt and blame.

*The Centrality of the Alcoholic.* The alcoholic family system tends to be organized around the real or perceived needs of the alcoholic and the alcoholic is the organizing principle or person around whom everything else revolves (Deutsch, 1982). Family members become so emotionally engaged and preoccupied with the alcoholic's drinking, and each other's responses to the drinking, that every drinking incident becomes part of a chain. The accumulated feelings and the individual's past reactions influence each family member's behavior and feelings on each new occasion of drinking. This can become an obsession that pervades the family whether the alcoholic is drinking or not; the first consideration of the family is to prevent and preempt the alcoholic's need to drink. Deutsch (1982) stated that healthier, more functional family systems are less centralized. They are not so exclusively organized around the real or perceived needs of any one member and there is no one organizing person or principle around whom everything else revolves.

*Denial and Shame.* Deutsch (1982) described alcoholic denial as an exaggerated form of a common defense mechanism that protects the alcoholic from seeing what the drinking is doing to him/herself and his or her loved ones. The alcoholic does this partly to avoid the guilt and shame, but mainly because acknowledging it would mean he/she would have to try to give up the alcohol. This denial is extremely flexible and accommodating and is equally characteristic of the alcoholic's spouse and children. The denial of

family members also progresses with the illness. For children of alcoholics, accepting their parents' denial is the path to peace and openly rejecting it is the gravest of offenses.

The habitual practice of denial and deception has profound consequences for children of alcoholics. They may methodically suppress all threatening feelings; experience a loss of values, because what they feel is right is subordinated to what is necessary and tolerable; retain deep-seated shame, the solution for which has always been isolation; and consistently confuse reality and fantasy (Deutsch, 1982, p. 41).

*Inconsistency, Insecurity, and Fear.* Deutsch (1982) described most active alcoholics as unpredictable and inconsistent, whether they are drinking or not. Alcoholics may show mercurial changes when they are drinking: going from withdrawn to generous to violent within a matter of minutes. The nonalcoholic parent is often equally inconsistent (e.g., sometimes the nonalcoholic parent yells at the alcoholic for drinking; other times he/she pours his/her drinks.). This parental inconsistency breeds insecurity in the children and once this insecurity has been established, it becomes a way of life. Fear is another emotion that permeates the child of an alcoholic. Deutsch (1982) stated, "Nothing contributes to children's insecurity and fear more than recurring violence" (p. 43), and many alcoholics are violent when drinking.

*Anger and Hatred.* It is understandable how anger comes to be one of the dominant emotions of children of alcoholics, given the previously described conditions in the family. "What anger can rival that of children who are repeatedly disappointed, neglected, or abused by the people they love and need the most?" (Deutsch, 1982, p. 47). However, these feelings of anger and hatred toward their parents can provoke guilt and anxiety in children of

alcoholics. This guilt and anxiety can be dealt with in a number of ways: many children deny these feelings; some turn their anger inward; others feel a generalized and helpless rage and their anger takes shape as chronic depression, self-pity, and deep feelings that life is not worth living; some children don't allow themselves to feel any anger; and still others feel their anger, but cannot directly express it and so act out their anger against safer targets (e.g., friends, siblings, authority figures, etc.) (Deutsch, 1982).

*Guilt and Blame.* According to Deutsch (1982), guilt coexists with fear and anger in an alcoholic home. A sense of responsibility and guilt is conveyed to the child every time the nonalcoholic parent enlists the child's help to prevent the drinking. Guilt and blame go hand in hand for children of alcoholics. If these children believe that they can, in some way, prevent the alcoholic's drinking, then they also believe that the other family members can prevent it. Hence, in addition to blaming themselves, they also blame other family members for the alcoholic's drinking.

It is important to keep in mind that the above characteristics may not be unique to the alcoholic family, and even relatively normal and healthy families share some of these characteristics in a much less powerful and destructive form. Additionally, these characteristics may also be exhibited, in comparable strength, by families in which a parent is dying, or schizophrenic, or violent (Deutsch, 1982).

Wegscheider-Cruse (1985) offered an additional view, in which she stated that "Children of alcoholics share an important common bond: Each has learned a strategy, a dysfunctional way to cope with the alcoholism or addiction that has crippled their family system (p. 34)." Young children of

alcoholics become para-alcoholics or para-dependents; they acquire role model attitudes and habits from both the alcoholic parent and the nonalcoholic spouse. However, instead of learning and imitating the healthy role model attitudes and habits of a functional family, these children of alcoholics learn and imitate their parents' dysfunctional behaviors and coping mechanisms (e.g., the alcoholic parent's medication of emotions, and the nonalcoholic parent's repression of emotion). Para-dependent children develop a chameleon-like personality and alter their behavior for protective purposes. "They can laugh, smile, look surprised or serious in an instant. The exterior display— the public performance— completely hides the hurt, anger, shame, and loneliness within. A divided self results: A self that gets approval and acceptance for being a chameleon, and a secret self, the inner person no one knows" (Wegscheider-Cruse, 1985, p. 40).

### Distress

Growing up in an alcoholic home has been described as a chronically stressful situation (Clair & Genest, 1987). Research has shown that adult children of alcoholics (ACAs) are more prone to psychological and physical distress and emotional problems than are adult children of nonalcoholics (nonACAs) and it is assumed that these problems are due to the alcoholic environment. Included in these problems are difficulties with: trust, intimacy, communication, role confusion, depression, decreased well-being, and low self-esteem, and cognitive distortions (Black, Bucky, & Wilder-Padilla, 1986; Lease, 1990; McKenna & Pickens, 1983; Plescia-Pikus, Long-Suter, & Wilson, 1988; Taliaferro & Aponte, 1990; Woititz, 1986).

Adult children of alcoholics have been found to have difficulty with making friends, intimacy, and social relationships in general. Children from alcoholic homes have a more difficult time relating to peers and forming lasting relationships as compared to children from nonalcoholic homes (Cork, 1969). Flannery (1986) found that the offspring of alcoholic parents are socially isolated, and avoid general social contacts. He postulated that perhaps they were embarrassed by the behavior of the alcoholic parent and avoided bringing friends home, or that they were ashamed of the family secret and avoided others for fear of revealing it inadvertently. Social isolation was the common pattern, although the offspring may have had one adult in whom they confided. He also hypothesized that ACAs are victims of psychological trauma with learned helplessness, which he described as "a condition in which they lose the capacity to appreciate the connections between their actions and their ability to influence their lives" (Flannery, 1986, p. 497).

Communication problems in ACAs have also been studied by Wegscheider-Cruse (1985), who stated that ACAs develop communication styles that impede honest sharing, prevent emotional intimacy, restrict healthy expression of feelings, foster dependency and reduce self-worth, avoid necessary conflict and produce tension, and neglect fun and pleasure. These communication styles tend to interfere with the forming of friendships and social interaction.

In a study of the interpersonal and emotional consequences of being an adult child of an alcoholic, Black et al. (1986) studied ACAs and nonACAs. Subjects had some professional or personal interest in alcoholism and were solicited via notices in magazines and journals on alcoholism. These subjects



provided information about family history, past and present drug and alcohol use, problems growing up in an alcoholic family, communication with significant others, and physical and sexual abuse. Black et al. stated that the ACAs reported significantly less communication during childhood with their parents, neighbors, friends the same age, teachers, counselors, and friends' parents than did the nonACAs. In addition, Black et al. found that, as children, ACAs did not utilize interpersonal resources, indicating that these resources were physically or emotionally not available, or were available but not used. They hypothesized that some reasons for this lack of utilization of support systems were that the children: a) felt ashamed and embarrassed by their parent's alcoholism, b) were confused and unable to identify the problem, c) were told not to talk to others about the drinking and that to do so would betray the family, d) felt that to talk about it would worsen the situation at home, e) feared rejection, and f) had no role models for open communication. ACAs were also reported to have significantly greater difficulty with trust, identifying and expressing feelings, and dependency than nonACAs. In addition, ACAs described themselves as being confused and depressed with greater regularity than nonACAs.

Other researchers have investigated the effects of social support on adult children of alcoholics. Pickett (1988/1989) studied alcoholic family environments by investigating the perceptions of women who grew up in alcoholic families. Female college students were assessed on their satisfaction with the social support they received and their perceptions of their family of origin. The women from alcoholic families of origin perceived their families as being less cohesive, less expressive, less interested in intellectual-cultural

activities, and placed less emphasis on moral-religious issues than did the women from non-alcoholic families of origin. In regard to social support, the female ACAs indicated that they were less satisfied with the emotional support, informational support, instrumental support, and overall social support that they received than were the nonACA females.

Social support was also looked at by Kashubeck (in press), who studied the relationship of parental alcoholism to psychological distress, social support and hardiness in college students. Results showed that parental alcoholism was positively related to psychological distress. In addition, higher levels of social support and hardiness were associated with lower levels of psychological distress. The author found no relationships between parental alcoholism and either hardiness or social support. Additionally, no mediating effects of social support and hardiness were found, indicating that social support and hardiness did not act as mediators in the relationship between psychological distress and parental alcoholism.

Although some researchers have found differences between ACAs and nonACAs, there are also researchers that have found no significant differences in personality characteristics or psychological distress between ACAs and nonACAs (e.g., Berkowitz & Perkins, 1988; Duprez, 1987). For example, Berkowitz and Perkins (1988) studied impulsiveness, self-depreciation, lack of tension, independence/autonomy, need for social support, directiveness, sociability, and other-directedness in college students. The authors also assessed attitudes, behaviors, social contexts, consequences, and personal and familial experiences with regard to the use of alcohol. ACAs were similar to their nonACA peers on all personality measures except

that they reported greater self-depreciation and male ACAs rated themselves significantly higher on autonomy than did male nonACAs.

To summarize, whereas some researchers have found more physical and psychological distresses and emotional problems in ACAs than in nonACAs, other researchers have found no differences. In addition, although researchers have looked at a wide range of emotional problems and distress in ACAs, two areas (self-esteem and depression) have been the focus of a number of researchers. Because of the emphasis and importance placed on these areas, they will be examined in depth.

### Self-Esteem

Evidence of low self-esteem or poor self concept in ACAs has been found by a number of researchers and clinicians (c.f., Berkowitz & Perkins, 1988). Plescia-Pikus et al. (1988), sampling both college students and the general population, focused their study on the low self-esteem, the achievement motive, and the unusually high stress seemingly associated with being a child of an alcoholic. They found that ACAs had significantly less well-being than nonACAs and that ACAs with low well-being exhibited a much higher stress response syndrome, as measured by stress intrusion and stress avoidance scores.

Lease (1990) studied subjects recruited from 12-step ACA and Al-Anon groups, client populations at university counseling centers, and classes at southern, midwestern, and eastern universities. Subjects were assessed for parental alcoholism, family process, self-esteem, adaptability and personal resourcefulness. In addition, information about alcohol use by the subject and family members, parental drinking style, social support network,

socioeconomic status (SES), and physical and sexual abuse was obtained. Results indicated that ACAs had significantly less self-esteem, ego strength, and resiliency and had more histories of sexual and physical abuse than nonACAs. In addition, the results suggest that self-esteem contributes to the development of resiliency in adult children of alcoholics.

Several researchers have studied self-esteem in conjunction with locus of control. Jaecques (1989) studied self-esteem and locus of control in ACAs and nonACAs from a variety of clinical and nonclinical settings. The results indicated that the ACAs had lower self-esteem than the nonACAs, but no differences between ACAs and nonACAs on locus of control were found. In contrast, Churchill, Broida, and Nicholson (1990) using college students as subjects, found no significant relationships between parental alcoholism and locus of control or self-esteem. In other words, they found no differences between ACAs and nonACAs on measures of self-esteem and locus of control. The authors questioned the hypothesis that being the child of an alcoholic was an explanation for a particular pattern of behavior and/or personality style; instead, they hypothesized that other factors may contribute to the problems (e.g. dysfunction in the home, which many ACAs experience).

In summary, although some researchers have found differences in self-esteem between ACAs and nonACAs, other researchers have found no differences. These conflicting findings indicate the need for further research in this area. In addition, as Churchill et al. (1990) stated above, there is a need for research investigating other possible factors (other than parental alcoholism) that may be contributing to the problems experienced by ACAs.

### Depression

The assertion that adult children of alcoholics have a high incidence of depression has been explored by a number of researchers (e. g., Jarmas, 1989; Taliaferro & Aponte, 1990; Tolton, 1988/1989). Cole (1988/1989) researched the personality characteristics of female adult children of alcoholics. Subjects were divided into two groups, a group of women whose fathers were alcoholic and a group of women in which neither parent was alcoholic. The results showed that female ACAs had significantly more psychological symptomatology than did female nonACAs, scoring significantly higher than nonACAs on such MMPI scales as Hypochondriasis, Hysteria, Paranoia, and Hypomania. ACAs also showed more depression and low self-esteem than nonACAs, and a great deal of underlying anger towards authority.

Taliaferro and Aponte (1990) investigated depression and cognitive distortions in college student ACAs and nonACAs. They concluded that ACAs reported significantly higher levels of depression than nonACAs and found a significant ACA by sex interaction, with female ACAs having higher levels of depression than male ACAs or controls. ACAs were also found to have a significantly higher expectancy for failure. These findings of higher levels of depression in ACAs, as compared to nonACAs, are consistent with much of the popular literature on ACAs and with some of the empirical literature on ACAs. Additionally, the specific findings of higher levels of depression in female ACAs are consistent with the literature findings of higher levels of depression in females, in general (e.g., Berkowitz & Perkins, 1988; Hirschfeld, Klerman, Clayton, Keller, & Andreasen, 1984; Halbreich, Vital-Herne, Goldstein, & Zander, 1984; Sowa & Lustman, 1984).

Depression has also been studied in ACAs through the application of specific models of depression. In studying the adult children of alcoholic fathers, their family systems, coping styles and depressive experiences, Jarmas (1989) matched college students whose fathers were alcoholic with a group of individuals whose parents were not alcoholics. The clinical characteristics of the adult children of alcoholics (ACAs) were evaluated using Blatt's (1974) model of depression, which is based on object relations theory and considers depressive experiences in relation to impairments at different levels of object representation.

Jarmas (1989) found that ACAs differed significantly in their perceptions of their families from nonACAs. ACAs described their families as having greater inconsistency, lower cohesion, less expressiveness, more conflict, less organization and poorer communication than did nonACAs. Parental inconsistency emerged as the single best discriminator between the ACA and nonACA groups. ACAs exhibited significantly greater introjective depression (characterized by low self-esteem, feelings of inferiority, guilt, worthlessness, and a sense of having failed to meet expectations) and aggressive defenses than did nonACAs, but showed no differences on anaclitic depression (characterized by feelings of helplessness and fears of abandonment) and intropunitive defenses (self-criticism and excessive guilt). The definition of introjective depression given above states that it is characterized by low self-esteem. Thus, this study can also be viewed as supporting differences in self-esteem in ACAs with ACAs having lower self-esteem than nonACAs. A significant group by gender interaction, with respect to alcohol-related problems, was also found with male ACAs showing

significantly more alcoholism than female ACAs or controls. Additionally, an association between alcoholism and disrupted family functioning was indicated, with ACAs manifesting distinct, identifiable, emotional characteristics such as: low self-esteem, higher levels of introjective depression, and having very different perceptions of their families (greater inconsistency, lower cohesion, less expressiveness, less organization, poorer communication, and more conflict) than do nonACAs.

Other researchers have investigated the psychopathology of ACAs who are also alcoholics themselves. McKenna and Pickens (1983) studied chronic-stage alcoholics and the effects of parental drinking status (neither parent alcoholic, one parent alcoholic, and both parents alcoholic) on Minnesota Multiphasic Personality Inventory (MMPI) scores. They found that the number of alcoholic parents was directly related to overall profile elevation, which suggests that alcoholism in the parents is associated with increased psychopathology, especially depression, acting out, and aggression, in their alcoholic children.

Conversely, some researchers have found no differences in depression between ACAs and nonACAs. Duprez (1987) investigated personality and psychological characteristics in ACA and nonACA college students. Two standardized assessment instruments were used to measure levels of depression and self-esteem and no significant differences between ACAs and nonACAs were found. Duprez's findings of no differences in levels of self-esteem and depression between ACAs and nonACAs are contrary to the view taken in the popular ACA (c.f., Woititz, 1983; Black, 1981) literature and the findings of other researchers.

Tolton (1988/1989) investigated whether adult daughters of alcoholics reported more depression than adult daughters of nonalcoholics. Female community volunteers were compared on several psychosocial factors related to depression: life events, coping responses, and social support. The only significant finding was that adult daughters of alcoholics reported more dysfunctional childhood family relationships than adult daughters of nonalcoholics. No differences were found between the two groups on depression scores, life events, coping responses or social support.

In summary, the research looking at depression in ACAs and nonACAs has revealed conflicting findings, with some researchers finding differences in depression between ACAs and nonACAs and other researchers finding no differences. This lack of agreement in the findings emphasizes the need for further research in this area. In addition, this conflict also indicates the need for the investigation of other possible causes of the depression (other than parental alcoholism) sometimes found in ACAs.

#### Methodological Problems

Conflicting findings in the literature, with some researchers finding differences between ACAs and nonACAs and other researchers finding no differences, can possibly be attributed to problems with the methodology of the research. Poor methodological quality has been a problem with much of the research on both children and adult children of alcoholics (Black, 1981; Heller, Sher & Benson, 1982; West & Prinz, 1987). For example, much of the research on ACAs has been done on college student and young adult populations. This could result in an underestimation of specific problem areas being identified, as both the clinical literature and clinical experience



suggest that ACAs do not experience the full psychological impact of growing up in an alcoholic home until later in their twenties (Black, 1981; Wegscheider, 1981). However, research done using just clinical subjects (another common practice) could result in an overestimation of problems in this population (the fact that the subjects are involved in some type of clinical setting indicates that these subjects are more likely to be severe cases and therefore, may be nonrepresentative of the overall population of ACAs) (Heller et al., 1983; West & Prinz, 1987). Therefore, some studies have garnered subjects from a combination of these settings, in order to get a more representative sample.

For example, Kashubeck and Christensen (1992), investigated within-group differences in psychological distress, social support, and hardiness among adult children of alcoholics (ACAs). They compared members of ACA support groups to college student ACAs that were not involved in any such support groups. Support group members reported greater distress than the college student ACAs, and males reported greater distress than females. The college student sample was also found to be more satisfied with the social support they received than was the support group sample. In addition, the support group ACAs scored lower than the college student ACAs on the personality construct of hardiness. Hardiness and social support were negatively correlated with psychological distress for both groups. The results of this study suggests that clinical ACA groups (in this case, ACA support groups) are more psychologically distressed than college student ACA groups. This finding supports the view that not all ACAs are alike or affected by parental alcoholism in the same way.

Bradley and Schneider (1990) studied interpersonal trust, self-disclosure and control in adult children of alcoholics and adult children of nonalcoholics. Subjects were obtained from support groups for adult children of alcoholics at a university counseling center and university psychology students. Results showed that ACAs had a higher need for interpersonal control, but no differences between the groups were found on trust or self-disclosure. Subjects with alcoholic fathers had higher scores on the control measure, while subjects with alcoholic mothers had lower trust scores. There were small but significant correlations found between distress associated with parental alcoholism and trust (lower) and reported involvement with alcohol (higher) in ACAs. These findings suggest that the sex of the alcoholic parent may be an important variable in understanding how the ACA was affected.

Lease (1990) also studied ACAs and nonACAs from a number of different populations (see earlier citation) and found ACAs had experienced more physical and sexual abuse, and had lower resiliency and self-esteem than nonACAs. In addition, physical abuse, low self-esteem and high intergenerational triangulation in the family of origin were found to be predictive of low resilience in ACAs.

Another important methodological consideration has to do with the assumption of uniformity of experience of ACAs. In much of the past research done on ACAs, it was assumed that all ACAs had similar experiences growing up in an alcoholic family. However, some researchers are beginning to stress the importance of not making this assumption and to examine whether differences in experience could be contributing to the conflicting findings on ACAs. For example, Ackerman (1987b) found that

living with an alcoholic parent was a major stressor for adult children of alcoholics; however, how this stress was handled and the many different responses created by this stress helped to explain why adult children were not all affected the same way. Possible intervening variables in the child of an alcoholic's experiences identified by Ackerman were: the degree of alcoholism experienced, the kind of alcoholic in the family, the child's perception of the experience, the child's resiliency to stress, the gender of the alcoholic and the child, the age at which the adult child was exposed to alcoholism, any positive offsetting factors while growing up and any cultural considerations and implications. The differential effects of these variables were not limited to childhood, but could be manifested in a variety of ways in adulthood (Ackerman, 1987b).

Ackerman's (1987b) findings that the stress of growing up in an alcoholic family does not affect all adult children the same way, coupled with studies that have found no differences between ACAs and nonACAs, (e.g., Berkowitz & Perkins, 1988; Duprez, 1987) brings into question whether it is the parental alcoholism itself that is causing the problems in ACAs or if there is another possible cause or causes. Clinicians have noticed that adults who grew up in dysfunctional families, where no parental alcoholism was involved, exhibit some of the same problems that adult children of alcoholics do. Lundberg (1990/1991, p. 39) summarized various family theorists' descriptions of a dysfunctional family as being "characterized by ineffective and dishonest communication, the failure to respond to family member's emotional needs, and rigidity in behaviors and views". The above

description of dysfunctional families is similar to both the popular and the clinical literature's description of alcoholic families.

### Dysfunction

Researchers searching for an explanation for the conflicting empirical findings on ACAs have begun to explore the impact of family dysfunction on adult children. Rubio-Stipec, Bird, Canino, Bravo, and Alegria (1991) examined the relationship between parental alcoholism and the risk for maladjustment in offspring. A community sample of children of alcoholics and children of parents with other psychiatric disorders were compared to children of "normal" parents using a multivariate model that took into account the effect that personal characteristics, as well as family environment, may have on the child's risk for psychopathology. Results showed that families with an alcoholic or psychiatrically disturbed parent had significantly more stressful life events and higher levels of marital discord and family dysfunction. It was also found that parental alcoholism coupled with an adverse family environment was associated with an increased risk of maladjustment in children. This finding suggests that children of alcoholics from dysfunctional families are at a greater risk of developing psychopathology.

Another study of family functioning and adult children of alcoholics was that of Sheridan (1989), who investigated the family dynamics and individual characteristics of ACAs. Subjects for three comparison groups were recruited: ACAs involved in recovery-oriented counseling and 12-Step programs; ACAs not involved in recovery services; and nonACAs, whose families of origin did not experience parental alcoholism or other major

family dysfunctions. They were assessed on three family variables (cohesion, adaptability and competence) and four individual variables (self-identity, self-esteem, issues with dependency and issues with control). These variables were used to assess the level of functioning and any relationship between family and individual members. ACAs revealed lower functioning in the three family areas and four individual areas than nonACAs. In regard to differences between the groups, nonACAs revealed the highest functioning in both family and individual areas, followed by the ACAs not in recovery, with ACAs in recovery showing the most dysfunction. Respondents with higher levels of family functioning also reported higher levels of individual functioning. These results imply that the amount of family dysfunction, in addition to parental alcoholism, may influence the level of functioning in individual ACAs.

Some researchers have found no differences between ACAs, adult children of dysfunctional families, and nonACAs from functional families. Lundberg (1989) studied the personality correlates of ACAs and adult children of dysfunctional families using college students. She compared the willingness to trust, fear of negative evaluation, and potential for addiction of ACAs, adult children of dysfunctional families in which neither parent abused alcohol, and adult children of healthy, functional environments. Results showed no significant personality differences between ACAs and the other comparison groups. It should be noted, however, that subjects were classified as an adult child of an alcoholic if parental alcoholism was present, regardless of whether or not they came from a dysfunctional family. If it is the dysfunction in the family that is causing the problems or the differences

in personality, rather than the alcoholism per se, then the fact that the ACAs from dysfunctional families were not separated from the ACAs from functional families could be an explanation for why no personality differences between groups were found.

In her subsequent study on lack of trust, fear of disapproval and potential for addiction in ACAs and adults from dysfunctional families, Lundberg (1990/1991) compared ACAs who perceived their families as functional, ACAs who perceived their families as dysfunctional, adult children of dysfunctional families with no history of parental alcohol abuse, and adult children of functional families. Results showed that subjects from dysfunctional families (both ACA and nonACA) were significantly more fearful of negative evaluation than those from functional families. There were no other significant findings. The results of this study gives partial support to the view that perhaps it is not parental alcoholism that causes problems in some ACAs, but rather, that it is the dysfunction in the family that is problematic. In view of the fact that so few studies have been conducted comparing ACAs and adult children of dysfunctional families, more research is needed in this area.

Other researchers have also looked at the influence of family dysfunction on ACAs. In a comparative study of ACAs and nonACAs from equal levels of family dysfunction, Sollars (1989) looked at whether ACAs had a significantly greater number of attribute problems (a greater degree of psychiatric problems, a greater tendency to become alcoholic or to marry alcoholics, a greater tendency to divorce, a greater degree of marital dysfunction, a greater degree of somatic problems, and a lower level of family

income) than nonACAs. Subjects were graduate students and a clinical population from outpatient psychotherapy clinics and were at least 25 years old or older. Sollars (1989) concluded that when ACAs from dysfunctional and moderately functional families were compared, respectively, with nonACAs from dysfunctional and moderately functional families, no statistical differences were found between the groups. These findings imply that it is the level of family dysfunction that is influencing or contributing to the attribute problems, not the parental alcoholism per se.

Additional work has been done in this area (i.e., the influence of family functioning on ACAs) by Farnsworth (1988), who studied the intimacy capacity of female adults from functional and dysfunctional families. Intimacy problems in females from nonalcoholic, dysfunctional families and adult daughters from alcoholic families were investigated. Subjects were female volunteers from the community aged 20 to 35 who had lived with their family of origin at least until the age of 12. Farnsworth (1988) found that there was little difference in intimacy adjustment among adult daughters from dysfunctional families, regardless of parental alcoholism. However, a significant difference in intimacy adjustment between adult daughters from dysfunctional families and adult daughters from families with no identified problems was found. Additionally, adult daughters of alcoholics were indistinguishable from adult daughters from dysfunctional families with regard to intimacy adjustment and their perception of their childhood family relationships. These results concur with the results of the previous study, again finding that it seems to be the family dysfunction that influences functioning, regardless of parental alcoholism.

Still another researcher that looked at the effects of family environment was Brower (1988), who investigated the influence of family environment on the social adjustment of ACAs. He did this by looking at whether the family environment exerts an influence on the social adjustment of ACAs independent of the severity and duration of parental drinking. Subjects were drawn from a national conference and a regional workshop on children of alcoholics, mailing lists of two state organizations for children of alcoholics, and participants in ACA therapy groups in three states. Brower (1988) found that parental alcoholism had no relationship to psychosocial maladjustment of children independent of family dysfunction. Greater family dysfunction resulted in increased psychosocial maladjustment and less positive adjustment. Therefore, this study suggests that it is the family dysfunction that plays the pivotal role in accounting for impairment in ACAs.

Finally, Werner and Broida (1991) studied self-esteem and locus of control as a function of familial alcoholism and dysfunction. Subjects were professional adults that were divided into four groups: parental alcoholism only, parental alcoholism and family dysfunction, family dysfunction only, and neither parental alcoholism or family dysfunction. No differences between ACAs and nonACAs were found for self-esteem or locus of control. However, when comparing adults from dysfunctional families and adults from functional families, significant differences in self-esteem were found, with adults from dysfunctional families having lower self-esteem than adults from functional families, regardless of parental alcoholism. Therefore, being raised in an alcoholic family did not predict lower self-esteem or a more



external locus of control; instead, it was the dysfunction in the family that influenced self-esteem. Once again, it was found that it was the family dysfunction that influenced functioning, in this case level of self-esteem, and not the parental alcoholism per se.

In conclusion, all but one of the above studies (Lundberg, 1989) suggest that the functioning of the family of origin may be a more important factor than parental alcoholism in influencing adult functioning. Perhaps ACAs are simply a subset of a larger group of individuals from dysfunctional families in which the dysfunctional family environment, not necessarily the parental alcoholism, causes the vulnerability to difficulties in adult functioning.

#### Present Study

As stated previously, conflicting findings in the literature with regard to ACA— nonACA differences in distress, coupled with the research reviewed above and clinician's observations that adults from dysfunctional families, with no history of parental alcoholism, exhibit some of the same problems that ACAs do, has called into question whether it is the parental alcoholism itself that is causing the problems in ACAs or whether it is the level of dysfunction in the family that is causing the problems. Researchers have only recently begun to look at this possibility.

The purpose of this study was to assess whether ACAs have specific characteristics or problems directly related to parental alcoholism or whether they are simply a subset of a larger group of adult children from dysfunctional families. This study compared levels of depression and self-esteem in four groups: adult children of alcoholics from dysfunctional families (ACA-Ds),

adult children of alcoholics from functional families (ACA-Fs), adult children of dysfunctional families with no history of parental alcoholism (nonACA-Ds), and adult children of functional families with no history of parental alcoholism (nonACA-Fs).

Although self-esteem in ACAs has been investigated by a number of researchers (Plescia-Pikus et al., 1988; Lease, 1990; Jaecques, 1989; Churchill et al., 1990) with various results, very little research has been done comparing levels of self-esteem in ACAs and adult children of dysfunctional families. In fact, a review of the literature revealed only two such studies (Sheridan, 1989; Werner & Broida, 1991). Other researchers (c.f., Churchill et al., 1990) have questioned whether parental alcoholism is an explanation for a particular pattern of behavior and/or personality style (e.g., self-esteem), or if family dysfunction is a contributing factor. Churchill et al. (1990) also expressed a need for more research in this area.

Given this need for more and varied research, as stated above, the variable of self-esteem was a logical choice for inclusion in this study. It was hypothesized that there would be differences in self-esteem between adult children from dysfunctional families (ACA-Ds and nonACA-Ds) and those from functional families (ACA-Fs and nonACA-Fs), and that adult children from dysfunctional families would have similar levels of self-esteem, regardless of parental alcoholism.

Adult children of alcoholics have been described in the popular literature as having more depression than nonACAs (c.f., Woititz, 1986), and a number of researchers have studied depression in ACAs (Jarmas, 1989; Taliaferro & Aponte, 1990; Tolton, 1988/1989; Cole, 1988/1989). However, a

review of the literature revealed no studies comparing levels of depression in ACAs and adult children of dysfunctional families. The serious lack of research in this specific area, coupled with the conflicting results found by researchers investigating depression in ACAs and nonACAs, led to the inclusion of the variable of depression in this study. It was hypothesized that participants from dysfunctional families (ACA-Ds and nonACA-Ds) would have similar levels of depression, but that they would have more depression than participants from functional families (ACA-Fs and nonACA-Fs).

In addition, a review of the literature revealed gender differences in depression, with females exhibiting higher levels of depression than males (e.g., Berkowitz & Perkins, 1988; Hirschfeld et al., 1984; Halbreich, et al., 1984; Sowa & Lustman, 1984). Incorporating these previous findings of differences in gender, it was hypothesized that female participants would have higher levels of depression than male participants and females from dysfunctional families (ACA-Ds and nonACA-Ds) would have the highest levels of depression, regardless of parental alcoholism. Furthermore, since low self-esteem is associated with depression, it was hypothesized that female participants would have lower self-esteem than male participants, with females from dysfunctional families (ACA-Ds and nonACA-Ds) having the lowest self-esteem, regardless of parental alcoholism.

Specifically, the hypotheses for this study are as follows:

1. Adult children of dysfunctional families (ACA-Ds, nonACA-Ds) will have higher levels of depression than adult children of functional families (ACA-Fs, nonACA-Fs), regardless of parental alcoholism.

2. Adult children of dysfunctional families (ACA-Ds, nonACA-Ds) will have lower self-esteem than adult children of functional families (ACA-Fs, nonACA-Fs), regardless of parental alcoholism.
3. No differences in depression will be found between adult children of alcoholics from dysfunctional families (ACA-Ds) and adult children of dysfunctional families (nonACA-Ds).
4. No differences in self-esteem will be found between adult children of alcoholics from dysfunctional families (ACA-Ds) and adult children of dysfunctional families (nonACA-Ds).
5. Female participants in all four groups will have higher levels of depression than male participants in all four groups.
6. Females from dysfunctional families (ACA-Ds and nonACA-Ds) will have the highest levels of depression, regardless of parental alcoholism.
7. Female participants in all four groups will have lower self-esteem than male participants in all four groups.
8. Females from dysfunctional families (ACA-Ds and nonACA-Ds) will have the lowest self-esteem, regardless of parental alcoholism.

In addition, exploratory analyses will be conducted to look at general predictors of stress; however, no specific hypotheses are predicted.

## CHAPTER II

### METHOD

#### Participants

Participants were 201 introductory level psychology students at Drake University and Des Moines Area Community College who received extra credit for their participation. Drake University students were solicited through a sign-up sheet posted on the bulletin board outside of Olin 303. Des Moines Area Community College students were solicited through announcements made in introductory psychology classes.

Of the 201 participants, there were 73 males, 127 females, and one participant for which gender information was unavailable. The age of the participants ranged from 17 to 57 years of age with a mean age of 23.35 years. One hundred and seventy-four (86.6%) of the participants were Caucasian, 12 participants (6%) were African American, 5 participants (2.5%) were Asian, 1 participant (0.5%) was American Indian/Native American, 2 participants (1%) were Hispanic/Chicano-Latino, and 7 participants (3.5%) were other or did not indicate race/ethnicity. One hundred and thirty-three of the participants (66.2%) were single, 39 participants (19.4%) were married/partnered, 9 participants (4.5%) were separated/divorced, 2 participants (1%) were widowed, 2 participants (1%) were cohabitating, and 16 participants (8%) did not indicate relationship status or indicated other.

#### Instruments

Children of Alcoholics Screening Test (CAST). The CAST is a 30-item inventory designed to identify children of alcoholics (see Appendix A) and is appropriate for assessing individuals age nine years or older (Jones, 1981).

The inventory measures children's feeling, attitudes, perceptions, and experiences related to their parents' drinking behavior. Specifically, the CAST measures: 1) emotional distress associated with a parent's alcohol use/misuse; 2) perception of drinking-related marital discord between parents; 3) efforts to escape from alcoholism; 4) exposure to drinking-related family violence; 5) tendencies to perceive parents as alcoholics; and 6) desire for help (Pilat & Jones, 1985). Items in the inventory are arranged in a yes/no format and the total number of "yes" answers determines categorization as a child of an alcoholic. A Spearman-Brown split-half reliability coefficient of .98 has been reported for the CAST (Jones, 1983; Pilat & Jones, 1985). Pilat and Jones (1985) correlated ACA and nonACA group scores with the total CAST scores and reported a validity coefficient of .78 ( $p < .0001$ ). A cut-off score of six or more reliably identified 100% of the children of clinically-diagnosed alcoholics and 100% of the self-reported children of alcoholics. However, there can be a problem with false positives. Therefore, to minimize the inclusion of false positives in the ACA category, a score on the CAST of eight and above, or a score of six or above and an affirmative or maybe answer to either of the following questions, "Is/Was your father an alcoholic?", "Is/Was your mother an alcoholic?", were used in this study. The CAST has been shown to be a valid and reliable screening test (Jones, 1983).

Family Relationship Index (FRI). The Family Relationship Index is a 27-item index that is composed of three subscales (Cohesion, Expressiveness, and Conflict) of the Family Environment Scale (see Appendix B) and measures the quality of family relationships (Moos & Moos, 1986). Each subscale is composed of nine true-false items. The subscale scores are formed

from the mean of the nine items, while the FRI score is formed from the mean of the three subscores, with Conflict negatively weighted in the formula (Hoge, Andrews, Faulkner, & Robinson, 1989). Moos and Moos (1986, p. 2) described these subscales as:

1. Cohesion: the degree of commitment, help, and support family members provide for one another.
2. Expressiveness: the extent to which family members are encouraged to act openly and to express their feelings directly.
3. Conflict: the amount of openly expressed anger, aggression, and conflict among family members.

The index has high internal consistency and good construct validity (Holahan & Moos, 1981). Tolton (1989) reported a high internal consistency as demonstrated in a Cronbach's alpha coefficient of .89. The index has also been used as an overall measure of family support (Moos & Moos, 1986). In addition, Billings and Moos (1985) reported a stability coefficient of  $r = .61$  for the composite measure based on a 12-month pre- and posttreatment assessment.

Beck Depression Inventory (BDI). The revised Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) is a 21-item, Likert-scaled inventory designed to assess the severity of depression in adolescents and adults (see Appendix C). The revised BDI replaces the original BDI developed by Beck, Ward, Mendelson, Mock, and Erbaugh (1961). The BDI is composed of 21 depressive symptoms and attitudes which can be rated on a 4-point scale ranging from 0 to 3 in terms of severity (Beck & Steer, 1987). Lightfoot and Oliver (1985, cited in Beck & Steer, 1987) reported a test-retest reliability of .90. Beck, Steer, & Garbin (1988) reported that the revised BDI has a high internal consistency in both clinical and nonclinical populations (mean coefficient

alphas of .86 and .81, respectively) . In addition, meta-analyses found a mean correlation of .72 when comparing the BDI with clinical ratings of depression for psychiatric patients, which indicates the BDI is a valid measure of depression (Beck, Steer, & Garbin, 1988).

Coopersmith Self-Esteem Inventory (SEI). The Adult Form of The Coopersmith Self-Esteem Inventory (see Appendix D) consists of twenty-five items designed to measure evaluative attitudes toward the self in social, academic, family, and personal areas of experience (Coopersmith, 1981). The SEI Adult Form was adapted from the SEI School Short Form and includes language related to older persons. The Adult Form consists of 25 short statements (such as, "I'm a lot of fun to be with") that are answered "like me" or "unlike me" and can be used with persons sixteen years of age and older (Coopersmith, 1981). Peterson and Austin (1985) reported that the Coopersmith Inventories are reliable and stable, with an impressive amount of information bearing on their construct validity. In addition, they are among the best known and most widely used of the various self-esteem measures. In another review, Adair (1984) found the SEI to be well researched, well documented, and widely used. In a study of 103 college students, Bedeian, Geagud, and Zmud (1977) reported an internal consistency of .74 for males and .71 for females as measured by a Kuder-Richardson reliability estimate (KR20). Additionally, Bedeian, et al. (1977) reported a test-retest reliability coefficient of .80 for males and .82 for females.

Demographic Questionnaire. The demographic survey was developed to obtain information about the participant's age, gender, ethnicity, relationship status, and parent's relationship status (see Appendix E).



Participants were asked about parental alcoholism in order to help with the identification of ACAs, and were asked about their own drinking behavior in order to assess their frequency and amount of alcohol use. Additionally, questions about past therapy and Alateen, Al-Anon, and Adult Children of Alcoholics experience were asked.

In addition, there is some question whether all adult children of alcoholics have had similar experiences in growing up in an alcoholic home. If the within-group experiences of ACAs were significantly different, there is a possibility that these differences in experience could be influencing or contributing to any differences in depression and/or self-esteem that may be found. Therefore, questions pertaining to the experience of growing up in an alcoholic family were asked in order to ascertain possible differences in experience between ACAs. Participants were asked about physical abuse, witnessing spousal abuse, the frequency and place of father's/mother's drinking, father's/mother's behavior while drinking, the quality of their parent's relationship, and how significantly affected they were by their father's/mother's drinking. For the questions pertaining to the effect of father's/mother's drinking, response was made by means of a five-point Likert scale with 1 signifying extremely affected and 5 signifying not at all affected, and for the question pertaining to the quality of their parent's relationship, response was made by means of a five-point Likert scale with 1 signifying excellent and 5 signifying poor.

#### Procedure

Participants received a packet containing an informed consent and the instruments described above. In order to insure the anonymity of the

participants, all items in the packet were labeled with an identification number. Participants were asked to read and sign the informed consent which was collected separately from the packet. Order of presentation of the instruments was counterbalanced in order to control for any systematic order effects. After completing the inventories, participants were debriefed through a handout which described the purposes of the research and gave sources of information and support for adult children of alcoholics (See Appendix G).

### Data Analysis

Participant Grouping. Participants were grouped according to parental alcoholism (alcoholic, nonalcoholic) and family function (functional, dysfunctional). Parental alcoholism was determined by score on the Children of Alcoholics Screening Test (CAST). Participants with a CAST score of eight and above, or a score of six or above and an affirmative or maybe answer to the question "Is/Was your father/mother an alcoholic?" were classified as ACAs; all others were classified as nonACAs. Family function was determined by total score on the Family Relationship Index (FRI). Participants with scores in the upper 40% were classified as being from functional families, participants with scores in the lower 40% were classified as being from dysfunctional families, and those participants with scores in the middle 20% were classified as neither functional or dysfunctional and their data was not used. Of the remaining 163 participants, 21 were classified as adult children of alcoholics from functional families (ACA-Fs), 36 were classified as adult children of alcoholics from dysfunctional families (ACA-Ds), 45 were classified as adult children of nonalcoholics from dysfunctional

families (nonACA-Ds), and 61 were classified as adult children of nonalcoholics from functional families.

Analyses. Preliminary analyses using Kruskal-Wallis nonparametric tests (with Bonferroni adjustment) were conducted on the variables of gender, race/ethnicity, socioeconomic status, relationship status, quality of parents' relationship, drinking behavior (frequency and quantity), physical abuse, and witnessing spousal abuse between parents, in order to ascertain whether there were differences between members of the four groups on variables that could possibly influence or contribute to any differences in depression and/or self-esteem that may be found. In addition, a one-way analysis of variance (ANOVA) of age by group was performed in order to determine whether age differences existed between groups.

Chi-square analyses (with Bonferroni adjustment) were performed on items pertaining to experiences of growing up in an alcoholic family, in order to assess possible differences in experience between ACAs (ACA-Ds and ACA-Fs).

A three-way multivariate analysis of covariance (MANCOVA) with family function (functional, dysfunctional), parental alcoholism (alcoholic, nonalcoholic), and gender as independent variables, the BDI and SEI as dependent variables, and age and quality of parents' relationship as covariates was performed in order to test Hypotheses 1-8. Since the results of the MANCOVA were significant, follow-up univariate analyses of covariance (ANCOVAs) were performed on the dependent variables.

Additionally, in order to further explore possible predictors of depression and self-esteem, multiple regression analyses were performed on

both the BDI and the SEI, using the alcoholic family experience questions, age, gender, and the three subscales of the FRI as regression variables.

## CHAPTER III

### RESULTS

#### Participant Grouping

As previously stated, participants were placed into one of four groups (ACA-F, ACA-D, nonACA-D, nonACA-F) according to parental alcoholism (alcoholic, nonalcoholic) and family function (functional, dysfunctional), with parental alcoholism determined by score on the CAST and family functioning determined by total score on the FRI. The means and standard deviations for the CAST and the FRI (Total and subscale scores) by group are reported in Table 1. Additionally, in reviewing the overall FRI scores, ACA-Ds and nonACA-Ds had similar scores, as did ACA-Fs and nonACA-Fs, with ACA-Ds scoring the lowest of the four groups (indicating more dysfunction) and nonACA-Fs scoring the highest of the four groups (indicating higher functioning). Furthermore, although the differences were not significant, ACA-Ds reported more conflict in their families compared to nonACA-Ds and ACA-Fs also reported more conflict compared to nonACA-Fs (see Table 1).

#### Preliminary Analyses

Kruskal-Wallis nonparametric tests (with Bonferroni adjustment) were conducted in order to determine if there were differences between members of the four groups (ACA-F, ACA-D, nonACA-D, and nonACA-F) on variables (demographic, family experience, and personal alcohol use) that could possibly influence or contribute to any differences in depression and/or self-esteem that may be found. Significant differences were found with regard to perceptions of the quality of the parents' relationship ( $H = 50.64, p < .0001$ ),

Table 1  
Means and Standard Deviations on CAST and FRI (Total & Subscales) by  
Group.

Variables	Means/(Standard Deviations)			
	ACA-F	ACA-D	nonACA-D	nonACA-F
<b>CAST</b>	13.95 (6.06)	16.33 (5.84)	0.73 (1.21)	0.46 (1.48)
<b>FRI</b>				
Total	12.90 (2.30)	0.97 (3.61)	1.93 (2.82)	13.03 (2.14)
Cohesion	8.29 (0.64)	3.31 (2.07)	3.87 (2.17)	8.20 (1.00)
Expression	7.19 (1.44)	3.31 (2.32)	3.60 (1.68)	6.74 (1.54)
Conflict	2.57 (1.60)	5.64 (1.87)	5.53 (1.80)	1.90 (1.76)

*Note.* ACA-F = adult children of alcoholics from functional families; ACA-D = adult children of alcoholics from dysfunctional families; nonACA-D = adult children of dysfunctional families; nonACA-F = adult children of functional families. CAST = Children of Alcoholics Screening Test; FRI = Family Relationship Index. Subscale of Conflict is negatively weighted in calculation of FRI.

and the presence of spousal abuse between parents ( $H = 16.40, p < .0009$ ). No significant differences were found between groups for gender ( $H = 2.88, p > .41$ ); race/ethnicity ( $H = 5.27, p > .15$ ); socioeconomic status ( $H = 11.34, p > .01$ ); participant's relationship status ( $H = 10.60, p > .01$ ); participant's frequency of alcohol use per month ( $H = 3.23, p > .36$ ); participant's average quantity of alcohol consumed ( $H = 2.42, p > .49$ ); or whether the participant was the victim of physical abuse as a child ( $H = 6.75, p > .08$ ) (see Tables 2 and 3).

Since significant differences between groups were found for both quality of parents' relationship and spousal abuse between parents, Mann-Whitney U tests were performed on these variables in order to determine which groups differed significantly. Significant differences in the quality of parents' relationship were found between ACA-Fs and nonACA-Fs ( $M = 3.14, SD = 1.01$ ;  $M = 1.90, SD = .94$ , respectively;  $U = 241.5, p < .0001$ ); between ACA-Ds and nonACA-Fs ( $M = 3.47, SD = 1.13$ ;  $M = 1.90, SD = .94$ , respectively;  $U = 339.0, p < .0001$ ); and between nonACA-Ds and nonACA-Fs ( $M = 3.07, SD = 1.03$ ;  $M = 1.90, SD = .94$ , respectively;  $U = 567.0, p < .0001$ ), indicating that nonACA-Fs gave the quality of their parents' relationship a significantly better rating than did any other group. Consequently, the quality of parents' relationship variable was used as a covariate in future analyses. Additionally, significant differences in response to the question on the presence of spousal abuse between parents were found between ACA-Fs and nonACA-Fs (33% yes, 3.3% yes, respectively;  $U = 448.0, p < .0002$ ); and between ACA-Ds and nonACA-Fs (27.8% yes, 3.3% yes, respectively;  $U = 829.0, p < .0004$ ) indicating that both ACA-Fs and ACA-Ds reported witnessing significantly more abuse between their parents than did nonACA-Fs. Given the differences found

Table 2  
Means and Standard Deviations on Participants' Alcohol Consumption  
and Quality of Parents' Relationship by Group.

Variables	Means/(Standard Deviations)			
	ACA-F	ACA-D	nonACA-D	nonACA-F
Frequency of Alcohol Use Per Month	3.38 (1.43)	3.36 (1.62)	3.71 (1.36)	3.13 (1.64)
Quantity of Alcohol Use Per Month	2.67 (1.85)	3.03 (1.96)	2.82 (1.67)	3.21 (1.86)
Quality of Parents' Relationship	3.14 (1.01)	3.47 (1.13)	3.07 (1.03)	1.90 (0.94)

*Note.* ACA-F = adult children of alcoholics from functional families; ACA-D = adult children of alcoholics from dysfunctional families; nonACA-D = adult children of dysfunctional families; nonACA-F = adult children of functional families.



Table 3  
 Percentage of Affirmative Answers to Witnessing Spousal Abuse  
 and Experiencing Physical Abuse by Group.

Variable	Group			
	ACA-F	ACA-D	nonACA-D	nonACA-F
Spousal Abuse	33%	27.8%	13.3%	3.3%
Physical Abuse	19%	19.4%	22.2%	4.9%

*Note.* ACA-F = adult children of alcoholics from functional families; ACA-D = adult children of alcoholics from dysfunctional families; nonACA-D = adult children of dysfunctional families; nonACA-F = adult children of functional families.

between groups in the witnessing of spousal abuse, a one-way multivariate analysis of variance (MANOVA) was performed in order to determine if witnessing spousal abuse between parents was associated with differences in levels of depression and self-esteem. The MANOVA was significant, ( $F(2,197) = 3.44, p < .03$ ), with follow-up univariate analyses of variance (ANOVAs) indicating a significant effect of spousal abuse on depression, ( $F(1,198) = 6.03, p < .02$ ), but no significant effect on self-esteem, ( $F(1,198) = 1.05, p < .31$ ).

A one-way analysis of variance (ANOVA) of age by group was performed in order to determine whether age differences existed between groups. The ANOVA was significant, ( $F(3, 158) = 4.39, p < .005$ ). A multiple range test using Scheffe's procedure indicated significant differences in age ( $p < .05$ ) between ACA-Ds ( $M = 24.80, SD = 9.29$ ) and nonACA-Ds ( $M = 19.98, SD = 2.66$ ), and between nonACA-Ds ( $M = 19.98, SD = 2.66$ ) and nonACA-Fs ( $M = 24.15, SD = 8.11$ ). Consequently, the variable of age was used as a covariate in future analyses.

As stated previously, there is some question whether all adult children of alcoholics have had similar experiences in growing up in an alcoholic home. If the experiences of some ACAs were significantly different than the experiences of other ACAs (e.g., alcoholic's incapacity to function as a parent, abuse by alcoholic, alcoholic drunk every night, alcoholic passive, etc.), there is a possibility that these differences in experience could be influencing or contributing to any differences in depression and/or self-esteem that may be found. In order to assess possible differences in experience between ACAs (ACA-Ds and ACA-Fs), chi-square analyses (with Bonferroni adjustment)

were performed on items pertaining to experiences of growing up in an alcoholic family. No significant differences between groups were found for any of these items (see Table 4), indicating that the two groups do not differ on variables related to the experience of parental drinking. The number and percentage of both ACA groups (ACA-F and ACA-D) responding affirmatively to the above variables are also presented in Table 4.

#### Multivariate Analyses of Covariance

Prior to running a multivariate analysis of covariance, a Pearson  $r$  correlation was run on the variables of depression and self-esteem in order to establish that these two variables were, in fact, correlated. Results showed these variables to be negatively correlated ( $r = -0.69, p < .0005$ ) with high levels of depression being correlated with low self-esteem, and low levels of depression correlated with high self-esteem.

Since significant differences between groups were found for age, the quality of parents' relationship, and spousal abuse between parents, age and the quality of parents' relationship were used as covariates; however, spousal abuse could not be used as a covariate since it was a dichotomous as opposed to a continuous variable. In addition, spousal abuse between parents was not used as as an independent variable since its addition would result in insufficient cell sizes for an accurate multivariate analysis of covariance (MANCOVA). Therefore, a series of three-way MANCOVAs were performed in order to ascertain whether the variable of spousal abuse between parents interacted with the other independent variables (family function, parental alcoholism, and gender), thus creating a confound.

Table 4

Number/Percentage of ACAs Responding Yes to Alcoholic Family Experience Questions.

Variable	ACA-F	ACA-D	Chi Square
Father Alcoholic			0.22
Yes	11 (52.4%)	21 (58.3%)	
Maybe	6 (27.3%)	7 (19.4%)	
Mother Alcoholic			0.11
Yes	4 (19%)	8 (22.2%)	
Maybe	1 (4.5%)	2 (5.6%)	
Therapy	9 (42.9%)	16 (44.4%)	0.01
Al-Anon, ACA	4 (19%)	12 (33.3%)	1.34
Physical Abuse	4 (19%)	7 (19.4%)	0.007
Spouse Abuse	8 (36.4%)	10 (27.8%)	0.20
Father's Behavior While Drinking			
Verbally Belligerent	7 (33.3%)	18 (50%)	1.50
Offensive/Embarrassing	4 (19%)	19 (52.8%)	6.27
Abusive-Physically/Verbally	5 (23.8%)	15 (41.7%)	1.86
Passive	3 (14.3%)	4 (11.1%)	0.12
Carefree	6 (28.6%)	10 (27.8%)	0.004
Other	3 (14.3%)	2 (5.6%)	1.26
Father didn't drink	2 (9.5%)	1 (2.8%)	1.21
Mother's Behavior While Drinking			
Verbally Belligerent	1 (4.8%)	3 (18.3%)	0.26
Offensive/Embarrassing	2 (9.5%)	5 (13.9%)	0.23
Abusive-Physically/Verbally	0	3 (8.3%)	1.85
Passive	3 (14.3%)	9 (25%)	0.92
Carefree	5 (23.8%)	5 (13.9%)	0.90
Other	3 (14.3%)	4 (11.1%)	0.12

Table 4 Continued

Variable	ACA-F	ACA-D	Chi Square
Mother didn't drink	8 (38.1%)	15 (41.7%)	0.07
Frequency Father's Drinking			2.90
Never	2 (9.5%)	1 (2.8%)	
1 to 5 times a year	1 (4.8%)	1 (2.8%)	
6 to 11 times a year	0	0	
Once a month	0	1 (2.8%)	
2 to 3 times per month	1 (4.8%)	2 (5.6%)	
1 to 2 times per week	4 (19%)	4 (11.1%)	
3 to 4 times per week	3 (14.3%)	8 (22.2%)	
Nearly every day	10 (47.6%)	18 (50%)	
Frequency Mother's Drinking			5.16
Never	5 (23.8%)	10 (27.8%)	
1 to 5 times a year	3 (14.3%)	10 (27.8%)	
6 to 11 times a year	1 (4.8%)	0	
Once a month	4 (19%)	5 (13.9%)	
2 to 3 times per month	0	1 (2.8%)	
1 to 2 times per week	3 (14.3%)	2 (5.6%)	
3 to 4 times per week	2 (9.5%)	2 (5.6%)	
Nearly every day	3 (14.3%)	6 (16.7%)	
Father's Drinking Place			5.32
Home	4 (19%)	7 (19.4%)	
Away	4 (19%)	8 (22.2%)	

Table 4 Continued

Variable	ACA-F	ACA-D	Chi Square
Both	10 (47.6%)	20 (55.6%)	
Mother's Drinking Place			1.87
Home	8 (38.1%)	8 (22.2%)	
Away	2 (9.5%)	5 (13.9%)	
Both	3 (14.3%)	8 (22.2%)	
How Affected By Father's Drinking			4.03
Extremely	0	5 (13.9%)	
Strongly	5 (23.8%)	6 (16.7%)	
Somewhat	6 (28.6%)	12 (33.3%)	
Slightly	4 (19.0%)	5 (13.9%)	
Not At All	6 (28.6%)	7 (19.4%)	
How Affected By Mother's Drinking			1.71
Extremely	1 (4.8%)	4 (11.1%)	
Strongly	1 (4.8%)	4 (11.1%)	
Somewhat	2 (9.5%)	3 (8.3%)	
Slightly	1 (4.8%)	1 (2.8%)	
Not At All	15 (71.4%)	21 (58.3%)	

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*Note.* ACA-F = adult children of alcoholics from functional families; ACA-D = adult children of alcoholics from dysfunctional families.

The first in this series of MANCOVAs was a three-way MANCOVA with family function (functional, dysfunctional), gender, and spousal abuse between parents as independent variables, depression and self-esteem as dependent variables, and age and quality of parents' relationship as covariates. Results showed no significant two-way interactions for gender by spousal abuse ( $F(2, 151) = 0.83, p < .44$ ), or family function by spousal abuse ( $F(2, 151) = 1.10, p < .34$ ). In addition, the three-way interaction of family function, gender, and spousal abuse was not significant ( $F(2, 151) = 0.83, p < .44$ ).

The second in this series was a three-way MANCOVA with family function, parental alcoholism (alcoholic, nonalcoholic), and spousal abuse between parents as independent variables, depression and self-esteem as dependent variables, and age and quality of parents' relationship as covariates. Results showed no significant two-way interactions for spousal abuse by parental alcoholism ( $F(2, 151) = 0.66, p < .52$ ), or family function by spousal abuse ( $F(2, 151) = 0.95, p < .39$ ). In addition, the three-way interaction of family function, parental alcoholism, and spousal abuse was not significant ( $F(2, 151) = 0.02, p < .98$ ).

The third in this series of MANCOVAs was a three-way MANCOVA with parental alcoholism, gender, and spousal abuse between parents as independent variables, depression and self-esteem as dependent variables, and age and quality of parents' relationship as covariates. Results showed no significant two-way interactions for gender by spousal abuse ( $F(2, 187) = 1.01, p < .37$ ), or parental alcoholism by spousal abuse ( $F(2, 187) = 1.57, p < .21$ ). In addition, the three-way interaction of parental alcoholism, gender, and

spousal abuse was not significant ( $F(2, 187) = 0.09, p < .91$ ). In conclusion, it would appear that the possible confounding effects of the spousal abuse between parents variable are minimal; therefore, this variable was not included in subsequent analyses.

A three-way multivariate analysis of covariance (MANCOVA) with family function, parental alcoholism, and gender as independent variables, depression and self-esteem as dependent variables, and age and quality of parents' relationship as covariates was performed. Results showed a significant main effect of family function ( $F(2, 151) = 11.83, p < .0005$ ), with follow-up univariate analyses of covariance (ANCOVAs) indicating a significant effect of family function on both depression ( $F(1, 152) = 4.63, p < .03$ ) and self-esteem ( $F(1, 152) = 21.77, p < .0005$ ). Hypotheses 1 and 2, that the adult children of dysfunctional families would have higher levels of depression and lower self-esteem than the adult children of functional families, regardless of parental alcoholism, were supported. A significant main effect of parental alcoholism ( $F(2, 151) = 3.57, p < .04$ ) was found; however, follow-up ANCOVAs indicated no significant effects of parental alcoholism on depression ( $F(2, 152) = 0.14, p < .71$ ) or self-esteem ( $F(2, 152) = 2.83, p < .10$ ). In addition, contrary to predictions that female participants in all four groups would have higher levels of depression and lower self-esteem than male participants in all four groups, no significant main effect of gender was found ( $F(2, 151) = 0.18, p > .84$ ). Thus, Hypotheses 5 and 7 were not supported. No significant two-way interactions were found for gender by parental alcoholism ( $F(2, 151) = 0.084, p > .92$ ), gender by family function ( $F(2, 151) = 0.23, p > .79$ ), or parental alcoholism by family function ( $F(2, 151) = 0.35,$



$p > .70$ ). In addition, the three-way interaction of family function, parental alcoholism, and gender was not significant ( $F(2, 151) = 0.82, p > .44$ ). Because no main effect of gender and no interactions of gender and family function or of gender and parental alcoholism were found, Hypotheses 6 and 8, that females from dysfunctional families will have the highest levels of depression and the lowest self-esteem, regardless of parental alcoholism, were not supported. The means and standard deviations for the BDI and the SEI by gender and group are reported in Table 5.

Since significant main effects of family function were found for the BDI and the SEI, post hoc multiple range tests using Scheffe's procedure were performed in order to determine the nature of these differences. Results for the BDI showed significant differences ( $p < .05$ ) between nonACA-Fs and ACA-Ds, and between nonACA-Fs and nonACA-Ds, with both ACA-Ds ( $M = 11.58, SD = 7.92$ ) and nonACA-Ds ( $M = 10.40, SD = 8.01$ ) reporting greater levels of depression than nonACA-Fs ( $M = 6.51, SD = 5.10$ ). Additionally, ACA-Fs ( $M = 7.52, SD = 6.29$ ) did not differ in depression from any other group. No significant differences in depression were found between ACA-Ds and nonACA-Ds, thus supporting Hypothesis 3. Results for the SEI showed significant differences ( $p < .05$ ) between ACA-Fs and nonACA-Ds, between ACA-Fs and ACA-Ds, between nonACA-Fs and nonACA-Ds, and between nonACA-Fs and ACA-Ds indicating that both ACA-Fs ( $M = 81.71, SD = 12.49$ ) and nonACA-Fs ( $M = 76.46, SD = 17.05$ ) reported significantly higher self-esteem than either ACA-Ds ( $M = 58.56, SD = 24.06$ ) or nonACA-Ds ( $M = 56.44, SD = 23.00$ ). In support of hypothesis 4, no significant differences in self-esteem were found between ACA-Fs and nonACA-Fs or between ACA-Ds

Table 5  
Means and Standard Deviations on BDI and SEI by Gender and Group.

Variables	Means/(Standard Deviations)			
	ACA-F	ACA-D	nonACA-D	nonACA-F
<b>BDI</b>				
Males	9.17 (8.68)	9.20 (6.23)	10.47 (7.03)	5.48 (4.43)
Females	6.87 (5.29)	12.50 (8.41)	10.35 (8.79)	7.22 (5.46)
Both/All	7.52 (6.29)	11.58 (7.92)	10.40 (8.01)	6.51 (5.10)
<b>SEI</b>				
Males	77.33 (14.46)	62.40 (22.01)	56.21 (22.53)	79.04 (17.97)
Females	83.47 (11.70)	57.08 (25.06)	56.62 (23.78)	74.67 (16.40)
Both/All	81.71 (12.49)	58.56 (24.06)	56.44 (23.00)	76.46 (17.05)

*Note.* ACA-F = adult children of alcoholics from functional families; ACA-D = adult children of alcoholics from dysfunctional families; nonACA-D = adult children of dysfunctional families; nonACA-F = adult children of functional families. BDI = Beck Depression Inventory; SEI = Coopersmith Self-Esteem Inventory.

and nonACA-Ds. The means and standard deviations for the BDI and the SEI by group are reported in Table 5.

For exploratory purposes, the relationship between the number of alcoholic parents a subject had and the experience of growing up in an alcoholic family was explored. Because of the small sample size of ACAs with two alcoholic parents, statistical analyses such as Chi-Square were not able to be performed and only frequencies were examined (see Table 6). A greater percentage of ACAs with two alcoholic parents (60%) reported that they had received some type of therapy than did ACAs with one alcoholic parent (40%). However, more ACAs with one alcoholic parent (32.7%) reported having participated in some type of support group (Al-Anon, ACA, Alateen) than did those with two alcoholic parents (20%). In addition, ACAs with two alcoholic parents reported more physical abuse (30%) than did ACAs with one alcoholic parent (16.7%). The two alcoholic parent group also reported witnessing more spouse abuse (60%) than did the one alcoholic parent group (29.1%). Information pertaining to the father's behavior is also presented in Table 6. However, data pertaining to the mother's behavior is not presented as alcoholic mothers represented only 14% of the one parent group; consequently, comparisons would be uninformative.

In order to further explore possible predictors of depression and self-esteem, multiple regression analyses (see Table 7) were performed on both the BDI and the SEI, using the alcoholic family experience questions, age, gender, and the three subscales of the FRI as predictor variables. Results of the regression analyses for all subjects indicated that three variables, Expression; Mother's Behavior While Drinking—Other; and Conflict, accounted for

Table 6

Number/Percentage of ACAs Responding *Yes* to Alcoholic Family Experience. Questions  
by Number of Alcoholic Parents.

Variable	1 Alcoholic Parent	2 Alcoholic Parents
Father Alcoholic		
Yes	32 (58.2%)	8 (80%)
Maybe	15 (27.3%)	2 (20%)
Mother Alcoholic		
Yes	7 (12.7%)	8 (80%)
Maybe	1 (1.8%)	2 (20%)
Therapy	22 (40%)	6 (60%)
Al-Anon, ACA	18 (32.7%)	2 (20%)
Physical Abuse	9 (16.7%)	3 (30%)
Spouse Abuse	16 (29.1%)	6 (60%)
Father's Behavior While Drinking		
Verbally Belligerent	22 (40%)	3 (30%)
Offensive/Embarrassing	21 (38.2%)	4 (40%)
Abusive-Physically/Verbally	19 (34.5%)	4 (40%)
Passive	6 (10.9%)	0
Carefree	14 (25.5%)	4 (40%)
Other	6 (10.9%)	0
Father didn't drink	3 (5.5%)	0
Frequency Father's Drinking		
Never	3 (5.6%)	0
1 to 5 times a year	1 (1.9%)	0
6 to 11 times a year	0	0
Once a month	1 (1.9%)	0
2 to 3 times per month	3 (5.6%)	0

Table 6 Continued

Variable	1 Alcoholic Parent	2 Alcoholic Parents
1 to 2 times per week	9 (16.7%)	2 (20%)
3 to 4 times per week	13 (24.1%)	0
Nearly every day	24 (44.4%)	8 (80%)
Father's Drinking Place		
Home	13 (24.1%)	3 (30%)
Away	13 (24.1%)	3 (30%)
Both	26 (48%)	4 (40%)
How Affected By Father's Drinking		
Extremely	4 (7.5%)	1 (10%)
Strongly	12 (22.6%)	2 (20%)
Somewhat	17 (32.1%)	3 (30%)
Slightly	9 (17%)	4 (40%)
Not At All	11 (20.8%)	0

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*Note.* ACA = adult children of alcoholics

Table 7

Multiple Regression Results for BDI and SEI for All Subjects,  
ACAs and nonACAs

**For All Subjects**

Variable	<i>BETA</i>	<i>T</i>	<i>p</i>
<b>BDI</b>			
Expression	-0.227	-3.15	.002
Mother's Behavior While Drinking Other	-0.211	-3.03	.003
Conflict	0.191	2.69	.008
<b>SEI</b>			
Cohesion	0.340	4.67	.0001
Expression	0.259	3.57	.0005
Father's Behavior While Drinking Other	0.129	2.02	.05

**For ACAs**

Variable	<i>BETA</i>	<i>T</i>	<i>p</i>
<b>BDI</b>			
Expression	-0.372	-3.10	.003
<b>SEI</b>			
Expression	0.435	4.036	.0002
Father's Behavior While Drinking Abusive-Physically/Verbally	0.338	3.13	.003

Table 7 Continued

<u>For nonACAs</u>			
Variable	<i>BETA</i>	<i>T</i>	<i>p</i>
<b>BDI</b>			
Mother's Behavior While Drinking Other	-0.384	-4.39	.0001
Cohesion	-0.246	-2.96	.004
Mother's Behavior While Drinking Carefree	-0.222	-2.54	.01
<b>SEI</b>			
Cohesion	0.349	4.14	.0001
Mother's Behavior While Drinking Other	0.225	2.86	.005
Expression	0.215	2.48	.01

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*Note.* ACA = adult children of alcoholics, nonACA = adult children of nonalcoholics.

BDI = Beck Depression Inventory; SEI = Coopersmith Self-Esteem Inventory.

16.5% of the variance on the BDI ( $R^2 = 0.165$ , adjusted  $R^2 = 0.151$ ,  $F(3,178) = 11.73$ ,  $p < .0001$ ), and that three variables, Cohesion; Expression; and Father's Behavior While Drinking—Other, accounted for 27.9% of the variance on the SEI ( $R^2 = 0.279$ , adjusted  $R^2 = 0.267$ ,  $F(3,178) = 22.93$ ,  $p < .0001$ ). Results of the regression analyses for ACAs indicated that one variable, Expression, accounted for 13.8% of the variance on the BDI ( $R^2 = 0.138$ , adjusted  $R^2 = 0.124$ ,  $F(1,60) = 9.62$ ,  $p < .003$ ), and that two variables, Expression and Father Abusive—physically or verbally when drinking, accounted for 31.5% of the variance on the SEI ( $R^2 = 0.315$ , adjusted  $R^2 = 0.292$ ,  $F(2,59) = 13.56$ ,  $p < .0001$ ). Results of the regression analyses for nonACAs indicated that three variables, Mother's Behavior While Drinking—Other; Cohesion; and Mother's Behavior While Drinking—Carefree; accounted for 21.2% of the variance on the BDI ( $R^2 = 0.212$ , adjusted  $R^2 = 0.191$ ,  $F(3,116) = 10.39$ ,  $p < .0001$ ), and that three variables, Cohesion; Mother's Behavior While Drinking—Other; and Expression, accounted for 32.4% of the variance on the SEI ( $R^2 = 0.324$ , adjusted  $R^2 = 0.306$ ,  $F(3,116) = 18.50$ ,  $p < .0001$ ).



## CHAPTER IV

## DISCUSSION

The purpose of this study was to assess whether ACAs have specific characteristics or problems directly related to parental alcoholism or whether they are simply a subset of a larger group of adult children from dysfunctional families. This study compared levels of depression and self-esteem in four groups: adult children of alcoholics from dysfunctional families (ACA-Ds), adult children of alcoholics from functional families (ACA-Fs), adult children of dysfunctional families with no history of parental alcoholism (nonACA-Ds), and adult children of functional families with no history of parental alcoholism (nonACA-Fs). As hypothesized, the adult children of dysfunctional families reported higher levels of depression and lower self-esteem than the adult children of functional families, regardless of parental alcoholism. Also as expected, no differences in depression and self-esteem were found between adult children of alcoholics from dysfunctional families (ACA-Ds) and adult children of nonalcoholics from dysfunctional families (nonACA-Ds).

The above results support the findings of previous researchers that indicate that it is the level of dysfunction in the family, not the parental alcoholism per se, that influences functioning in general (Brower, 1988; Farnsworth, 1988) and self-esteem in particular (Werner & Broida, 1991; Soukup, 1990/1991). In addition, the results of this study, taken together with the previously mentioned research, could help explain why some researchers have found differences between ACAs and nonACAs while other researchers

have found no differences. If it is the family dysfunction that influences adult functioning, as opposed to the parental alcoholism, then the presence of adult children of dysfunctional families in both the control group and the experimental group would lead the researcher to find no differences between groups. Conversely, if adult children of dysfunctional families are found only in the experimental group and not in the control group, then differences between groups would be found.

Although the findings of this study support previous research on the influence of family functioning on adult functioning, it is important to keep in mind how family function/dysfunction is being measured. This consideration is especially important since research looking at family functionality, in conjunction with parental alcoholism, is a fairly recent development and there is currently no definitive measure of family functioning. This study used the Family Relationship Index (FRI), which measures the perceived quality of family interpersonal relationships as measured by the subscales of cohesion, expression, and conflict. While it is recognized that another instrument may not have divided the family functioning groups in exactly the same way, the researcher believed this particular instrument to be a good measure of family functioning, based on the use of the FRI by many other researchers (cf. Farnsworth, 1988; Tolton, 1988/1989) as well as the fact that the FRI is composed of subscales of the widely used and accepted Family Environment Scale (FES) (Moos & Moos, 1986).

As expected, ACA-Ds reported the most dysfunction in the family and nonACA-Fs reported the highest family functioning. In addition, the finding

that ACAs (ACA-Ds, ACA-Fs) scored higher than nonACAs (nonACA-Ds, nonACA-Fs) on the subscale of conflict (the amount of openly expressed anger, aggression, and conflict among family members) supports the view of alcoholic families being angry and conflictual. Deutsch (1982) reported that conflict is virtually unending and always triangulated with the bottle/drinking in an alcoholic family, and that anger becomes one of the dominant emotions of children of alcoholics, due to conditions of abuse, neglect, and disappointment found within the alcoholic family, .

However, it is interesting to note that ACA-Fs and nonACA-Fs scored similarly on the subscale of expression (the extent to which family members are encouraged to act openly and to express their feelings directly). This finding is contrary to what would be expected, given the view of the popular ACA literature, that ACAs have communication problems that restrict the healthy expression of feelings, and that there is a "Don't talk" rule that is in place in many alcoholic families (Wegscheider-Cruse, 1985, Black et. al, 1986). In addition, the fact that ACA-Fs and nonACA-Fs reported similar levels of expression indicates that not all ACAs experienced problems communicating within their families and emphasizes the need for researchers and counselors to examine differences in family functioning, as well as parental alcoholism, before deriving conclusions about ACAs.

Much of the previous research on adult children of alcoholics has been based on the assumption that growing up in an alcoholic family has a unique impact on ACAs, an impact not experienced by children who did not grow up in an alcoholic household. However, it appears that the family dysfunction experienced by some ACAs is not unique to children growing up in an

alcoholic family, and although alcoholism can be a contributor to family dysfunction, other factors can contribute to family dysfunction as well (e.g., chronic illness, mental illness, physical abuse, etc.).

In addition, while all alcoholic families have been described as dysfunctional or unhealthy families in the past, recently some researchers have acknowledged that while many alcoholic families may be dysfunctional, there also appears to be a population of alcoholic families that are able to function in a healthy manner despite the presence of alcohol (Ackerman, 1987b; Lundberg, 1990/1991; Steinglass, Bennett, Wolin, & Reiss, 1987). In the present study, results showed that not all adults who grew up in an alcoholic home experienced similar levels of function/dysfunction in their families, as indicated by the fact that this study found adult children of alcoholics from functional families (ACA-Fs). Of the 57 participants that were classified as adult children of alcoholics and whose data were used, 37% were classified as coming from a functional family and 63% were classified as coming from a dysfunctional family. In addition, of the 106 participants that were classified as adult children of nonalcoholics and whose data were used, 57.5% were classified as coming from a functional family and 42.5% were classified as coming from a dysfunctional family. Clearly, all alcoholic families are not necessarily dysfunctional families, and not all nonalcoholic families are necessarily functional families. Furthermore, the finding of ACA-Fs in this study indicates that ACAs are not simply a subset of a larger group of adult children from dysfunctional families and emphasizes the need for both researchers and counselors to look at the functioning of the individual's family and not just the presence or absence of parental alcoholism.

In order to assess whether differences in parental behaviors when using alcohol were possibly influencing or contributing to the differences in family functioning that were found, analyses to explore uniformity of experience in ACAs were performed on items pertaining to growing up in an alcoholic family (father/mother alcoholic, previous therapy or support group experience, physical abuse, spousal abuse, father's/mother's behavior while drinking, frequency of father's/mother's drinking, place of father's/mother's drinking, and how affected by father's/mother's drinking). No significant differences between ACA-Ds and ACA-Fs were found. Clearly, the differences in family functioning between ACAs in this study were not due to differences in the measured parental behavior when using alcohol, since no differences between ACA-Fs and ACA-Ds were found for these items. However, it is not clear whether differences may have been found with larger sample sizes, given the fairly small sample sizes for some of the items in this study. Further research on these items, using larger sample sizes would be beneficial. In addition, it is possible that other parental alcohol use behaviors, not measured by this study, influence or contribute to differences in family functioning. Therefore, further research on the effects of parental alcohol use behaviors on family functioning also would be beneficial.

Along these same lines, the relationship between the number of alcoholic parents a participant had and the experience of growing up in an alcoholic family was explored. The small number of ACAs with two alcoholic parents prohibited the use of statistical analyses such as Chi-Square; however, a comparison of percentages between ACAs with one or two alcoholic parents revealed that while a greater percentage of ACAs with two

alcoholic parents reported having received some type of therapy, ACAs with one alcoholic parent reported having more participation in some type of support group (Al-Anon, ACA, Alateen). It could be hypothesized that a greater percentage of ACAs with two alcoholic parents are in therapy because they are more distressed (McKenna & Pickens, 1983) than ACAs with one alcoholic parent; however, it should be noted that 40% of the ACAs with one alcoholic parent also reported having been in therapy at some point. In addition, it is beyond the scope of this study to make such assumptions since there is no way of knowing if the reason for seeking therapy was in any way related to parental alcoholism.

#### Family Violence

Having two alcoholic parents did seem to increase the likelihood of both having witnessed spouse abuse between parents and having experienced physical abuse as a child, as evidenced by the greater percentage of ACAs with two alcoholic parents responding affirmatively to these items. Although a seemingly logical conclusion, given the strong association between alcohol use and family violence, caution should be exercised before assuming that having two alcoholic parents automatically increases the risk of child abuse and spousal abuse in the family. The small number of two alcoholic parent ACAs in this study, as well as the nonexperimental nature of this data, prohibits making assumptions based on these data and should only be used as indicators for possible future research.

Since violence within the family is thought to contribute to family dysfunction and alcohol use is strongly associated with family violence (Hindman, 1979, cited in Steinglass, Bennett, Wolin, & Reiss, 1987), group

differences in the experience of family violence were examined. As expected, adult children of alcoholics reported witnessing more abuse between their parents than adult children of nonalcoholics. However, contrary to expectations, no differences between groups were reported with regard to participants' experience of physical abuse as a child.

Although not enough to be a significant difference, adult children from functional, nonalcoholic families reported (see Table 3) less physical abuse as a child. It would appear that, as would be expected, there is a trend toward more child abuse in both the families with parental alcoholism and in the dysfunctional families. Perhaps significant differences would have been found with larger sample sizes, given the fairly small sample sizes for some of the items in this study.

#### Participant's Alcohol Usage

Participants' alcohol usage (frequency of alcohol use per month and average quantity of alcohol consumed) was examined in order to assess if alcohol use could be influencing or contributing to differences in depression and self-esteem between groups. No differences between groups were found with regard to the participant's frequency of alcohol use per month or the average quantity of alcohol consumed by the participants, indicating that differences in depression and self-esteem between groups are not attributable to differences in alcohol usage.

The finding of no differences in alcohol usage between groups is contrary to what would be expected, given the view of both the popular literature on ACAs and previous research findings indicating adult children of alcoholics are more likely to be alcoholic. One possible explanation is the

fairly young age group of the majority of the participants. Perhaps the tendency towards alcoholism has not yet manifested in the ACAs. The high level of alcohol use by college students, overall, is yet another possible explanation of the finding of no differences in alcohol use between groups. Since college students, in general, report higher levels of alcohol use than the general population (Schall, Kemeny, & Maltzman, 1992), perhaps this elevated usage by college students supersedes any differences between ACAs and nonACAs that would be evidenced in the general population.

### Gender Differences

The hypotheses that female participants in all four groups would have higher levels of depression and lower self-esteem than males in all four groups were not supported. In addition, no interactions of gender by parental alcoholism, gender by family function, or gender by parental alcoholism by family function were found. Thus, the hypotheses that females from dysfunctional families would have the highest levels of depression and the lowest self-esteem, regardless of parental alcoholism, were not supported. These findings are contrary to the findings of some researchers who have found higher levels of depression and psychological distress for females in general (e.g., Young, Scheftner, Fawcett, & Klerman, 1990; Wright, O'Leary, & Balkin, 1989; Sowa & Lustman, 1984; Dean & Ensel, 1983; Russo & Sobel, 1981; Strickland, 1988), and for female ACAs in particular (Taliaferro & Aponte, 1990). On the other hand, some researchers have reported either no differences in distress for gender (Baron & Matsuyama, 1988; Lopez, Campbell, & Watkins, 1986) or that gender differences are declining (Kessler & McRae, 1981; McLanahan & Glass, 1985). Perhaps earlier findings of gender



differences on levels of depression and distress are no longer true. Another possible explanation is the possibility that the college student sample used in this study is somehow unique and not representative of the general population. For example, it may be that female college students are more resilient or have better coping skills than the general population, given the fact that they have made it to college, and thus gender differences in depression may be less likely in college student samples.

### Predictors of Depression and Self-esteem

In order to explore further possible predictors of depression and self-esteem, multiple regression analyses were performed on the BDI and the SEI, using the alcoholic family experience questions, age, gender, and the three subscales of the FRI as predictor variables. The predictor variables accounted for a small practical amount of the variance, as can be seen in the low  $R^2$  found for each group (see Table 7). Clearly, other factors, unmeasured in this study, are playing a significant role in participants' depression and self-esteem. In addition, although a practical amount of the variance was not explained, the FRI subscale of Expression was found to account for a portion of the variance of the SEI in all populations, and accounted for a portion of the variance of the BDI in all but one of the groups in the analysis. Consequently, more research into the variable of Expression (and/or variables with similar characteristics), as well as other potential predictors of depression and self-esteem, would be beneficial.

### Limitations

One limitation of this research is potential confusion concerning the identification of a stepparent as the alcoholic in the family. Although

provisions were made to allow participants to indicate if they were answering the CAST with regard to a stepparent, the same provisions were not made on the demographic form. Participants were only asked if their father, mother, or sibling was alcoholic, with no questions regarding stepparents. This could lead to confusion or possible misclassification of the participant with regard to parental alcoholism. However, since participants were automatically classified as an adult child of an alcoholic if they had a CAST score of eight or above, the potential for misclassification is a small one. Along this same line, it would be important to include in future demographic forms provisions for participants to be able to answer the questions pertaining to experiences of growing up in an alcoholic family with regard to stepparents. Because the impact of an alcoholic stepparent on a child can potentially be as great as that of an alcoholic parent, it would be important to clear up this potential confusion in any future research.

Another limitation of this study is the use of a college student sample. It may be that college student ACAs are not representative of ACAs in general. The fact that they have made it to college, in spite of growing up in an alcoholic home, may be indicative of more resiliency or better coping skills than found in the general population of ACAs. Replication of this study, utilizing a broader-based sample of ACAs, would be beneficial.

#### Implications and Future Directions

The primary finding of this study, that family function/dysfunction influences levels of depression and self-esteem in adults, regardless of parental alcoholism, has a number of implications. First, it emphasizes the need to look at family functioning, as well as parental alcoholism, when

conducting ACA research. The presence of adult children from dysfunctional families in either the control group and/or the experimental group could be contributing to the conflicting findings found in the ACA literature regarding whether or not there are differences between ACAs and nonACAs. Further research in this area could help alleviate the contradictions in the literature.

Second, as can be seen in this study's findings, adult children of dysfunctional families exhibit some of the same characteristics and problems that have previously been attributed to adult children of alcoholics (i.e., more depression, low self-esteem). Given the ACA literature's strong focus on psychological problems in ACAs, it is possible that counselors' awareness of potential problems in ACAs have been heightened such that particular problems or characteristics (e.g., more depression, low self-esteem, problems with intimacy, etc.) are automatically looked for when counseling ACAs. However, given the literature's relatively recent focus on family functioning, this same awareness may not be applied when counseling adult children from dysfunctional families. Consequently, it is important that counselors/therapists take into account the impact of family dysfunction on adult functioning, as well as any potential problems therein, and not focus on parental alcoholism exclusively.

On the other hand, it is also important that we are not biased toward pathology when counseling adult children of alcoholics. As previously mentioned, the literature's strong focus on psychological problems in ACAs may lead us to look for problems or pathology in ACAs that may not exist. This study's finding that it is the dysfunction in the family, not parental alcoholism per se, that influences levels of depression and self-esteem,

coupled with the finding of adult children of alcoholics from functional families, suggests that we could be wrongly searching for pathology in all ACAs that may not exist for some ACAs.

However, it is also important to keep in mind that this is just one study. Caution should be exercised before we assume that parental alcoholism has no effect on depression and self-esteem or other adult functioning. This is especially true given this study's finding of a main effect of parental alcoholism in the MANCOVA, but whose source of significance could not be explained in the follow-up ANCOVAs. Perhaps parental alcoholism is influencing depression and self-esteem in ways not measured by this study. Clearly, more research into the effects of both parental alcoholism and family functioning is needed.

### Conclusion

This study investigated the relationship between parental alcoholism, family functioning, and psychological distress, specifically, depression and self-esteem. Results indicated that family dysfunction predicted psychological distress (i.e., higher levels of depression and lower self-esteem), regardless of parental alcoholism. One implication of this finding is that we cannot assume that all ACAs are alike or that parental alcoholism affects all families in the same way. These findings also suggest that it would be more appropriate and beneficial to focus research efforts and attention on family functionality, rather than on a particular population, such as Adult Children of Alcoholics.

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APPENDIX A  
Children of Alcoholics Screening Test

In answering the questions below, you may answer with regard to your stepparent if that is more applicable than your biological parent. If you do answer with regard to a stepparent, please check here: \_\_\_\_\_

Instructions: Please check the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No".

YES	NO	QUESTIONS
_____	_____	1. Have you ever thought that one of your parents had a drinking problem?
_____	_____	2. Have you ever lost sleep because of a parent's drinking?
_____	_____	3. Did you ever encourage one of your parents to quit drinking?
_____	_____	4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
_____	_____	5. Did you ever argue or fight with a parent when he or she was drinking?
_____	_____	6. Did you ever threaten to run away from home because of a parent's drinking?
_____	_____	7. Has a parent ever yelled at or hit you or other family members when drinking?
_____	_____	8. Have you ever heard your parents fight when one of them was drunk?
_____	_____	9. Did you ever protect another family member from a parent who was drinking?
_____	_____	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
_____	_____	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
_____	_____	12. Did you ever wish your parent would stop drinking?
_____	_____	13. Did you ever feel responsible for and guilty about a parent's drinking?
_____	_____	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
_____	_____	15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking?
_____	_____	16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
_____	_____	17. Did you ever feel that you made a parent drink alcohol?

- \_\_\_\_ 18. Have you ever felt that a problem drinking parent did not really love you?
- \_\_\_\_ 19. Did you ever resent a parent's drinking?
- \_\_\_\_ 20. Have you ever worried about a parent's health because of his or her alcohol use?
- \_\_\_\_ 21. Have you ever been blamed for a parent's drinking?
- \_\_\_\_ 22. Did you ever think your father was an alcoholic?
- \_\_\_\_ 23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
- \_\_\_\_ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?
- \_\_\_\_ 25. Did you ever think your mother was an alcoholic?
- \_\_\_\_ 26. Did you ever wish you could talk to someone who could understand and help the alcohol related problems in your family?
- \_\_\_\_ 27. Did you ever fight with your brothers and sisters about a parent's drinking?
- \_\_\_\_ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
- \_\_\_\_ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
- \_\_\_\_ 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

APPENDIX B  
Family Relationship Index



Below you will find 27 statements about families. You are to decide which of these statements are true of your family of origin and which are false. If you think that the statement is *True* or mostly *True* of your family, check TRUE. If you think the statement is *False* or mostly *False* of your family, check FALSE.

You may feel that some of the statements are true for some family members and false for others. Mark TRUE if the statement is *True* for most members. Mark FALSE if the statement is *False* for most members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to you. So *do not* try to figure out how other members see your family, but *do* give us your general impression of your family for each statement.

#### TRUE FALSE STATEMENTS

- |     |     |   |
|-----|-----|---|
| ___ | ___ | 1. Family members really help and support one another.                                      |
| ___ | ___ | 2. Family members often keep their feelings to themselves.                                  |
| ___ | ___ | 3. We fight a lot in our family.  |
| ___ | ___ | 4. We often seem to be killing time at home.  |
| ___ | ___ | 5. We say anything we want to around home.  |
| ___ | ___ | 6. Family members rarely become openly angry.   |
| ___ | ___ | 7. We put a lot of energy into what we do at home.  |
| ___ | ___ | 8. It's hard to "blow off steam" at home without upsetting somebody.                        |
| ___ | ___ | 9. Family members sometimes get so angry they throw things.                                 |
| ___ | ___ | 10. There is a feeling of togetherness in our family.                                       |
| ___ | ___ | 11. We tell each other about our personal problems.   |
| ___ | ___ | 12. Family members hardly ever lose their tempers.  |
| ___ | ___ | 13. We rarely volunteer when something has to be done at home.                              |
| ___ | ___ | 14. If we feel like doing something on the spur of the moment we often just pick up and go. |
| ___ | ___ | 15. Family members often criticize each other.  |
| ___ | ___ | 16. Family members really back each other up.   |
| ___ | ___ | 17. Someone usually gets upset if you complain in our family.                               |
| ___ | ___ | 18. Family members sometimes hit each other.  |
| ___ | ___ | 19. There is very little group spirit in our family.  |
| ___ | ___ | 20. Money and paying bills is openly talked about in our family.                            |

- \_\_\_ 21. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
- \_\_\_ 22. We really get along well with each other.
- \_\_\_ 23. We are usually careful about what we say to each other.
- \_\_\_ 24. Family members often try to one-up or out-do each other.
- \_\_\_ 25. There is plenty of time and attention for everyone in our family.
- \_\_\_ 26. There are a lot of spontaneous discussions in our family.
- \_\_\_ 27. In our family, we believe you don't ever get anywhere by raising your voice.

APPENDIX C  
Beck Depression Inventory

Date: \_\_\_\_\_

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, 3) next to the one statement in each group which best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

- |  |  |
|--|--|
| <p>1    0 I do not feel sad.<br/>             1 I feel sad.<br/>             2 I am sad all the time and I can't snap out of it.<br/>             3 I am so sad or unhappy that I can't stand it.</p>  | <p>4    0 I get as much satisfaction out of things as I used to.<br/>             1 I don't enjoy things the way I used to.<br/>             2 I don't get real satisfaction out of anything anymore.<br/>             3 I am dissatisfied or bored with everything.</p> |
| <p>2    0 I am not particularly discouraged about the future.<br/>             1 I feel discouraged about the future.<br/>             2 I feel I have nothing to look forward to.<br/>             3 I feel that the future is hopeless and that things cannot improve.</p> | <p>5    0 I don't feel particularly guilty.<br/>             1 I feel guilty a good part of the time.<br/>             2 I feel quite guilty most of the time.<br/>             3 I feel guilty all of the time.</p>   |
| <p>3    0 I do not feel like a failure.<br/>             1 I feel I have failed more than the average person.<br/>             2 As I look back on my life, all I can see is a lot of failures.<br/>             3 I feel I am a complete failure as a person.</p>           | <p>6    0 I don't feel I am being punished.<br/>             1 I feel I may be punished.<br/>             2 I expect to be punished.<br/>             3 I feel I am being punished.</p>  |
|  | <p>7    0 I don't feel disappointed in myself.<br/>             1 I am disappointed in myself.<br/>             2 I am disgusted with myself.<br/>             3 I hate myself.</p>  |

\_\_\_\_\_ Subtotal Page 1

- 8    0 I don't feel I am any worse than anybody else.  
       1 I am critical of myself for my weaknesses.  
       2 I blame myself all the time for my faults.  
       3 I blame myself for everything bad that happens.
- 9    0 I don't have any thoughts of killing myself.  
       1 I have thoughts of killing myself, but I would not carry them out.  
       2 I would like to kill myself.  
       3 I would kill myself if I had the chance.
- 10   0 I don't cry any more than usual.  
       1 I cry more now than I used to.  
       2 I cry all the time now.  
       3 I used to be able to cry, but now I can't cry even though I want to.
- 11   0 I am no more irritated now than I ever am.  
       1 I get annoyed or irritated more easily than I used to.  
       2 I feel irritated all the time now.  
       3 I don't get irritated at all by the things that used to irritate me.
- 12   0 I have not lost interest in other people.  
       1 I am less interested in other people than I used to be.  
       2 I have lost most of my interest in other people.  
       3 I have lost all of my interest in other people.
- 13   0 I make decisions about as well as I ever could.  
       1 I put off making decisions more than I used to.  
       2 I have greater difficulty in making decisions than before.  
       3 I can't make decisions at all anymore.
- 14   0 I don't feel I look any worse than I used to.  
       1 I am worried that I am looking old or unattractive.  
       2 I feel that there are permanent changes in my appearance that make me look unattractive.  
       3 I believe that I look ugly.

\_\_\_\_\_ Subtotal Page 2

- 15 0 I can work about as well as before.  
 1 It takes an extra effort to get started at doing something.  
 2 I have to push myself very hard to do anything.  
 3 I can't do any work at all.
- 16 0 I can sleep as well as usual.  
 1 I don't sleep as well as I used to.  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.  
 3 I wake up several hours earlier than I used to and cannot get back to sleep.
- 17 0 I don't get more tired than usual.  
 1 I get tired more easily than I used to.  
 2 I get tired from doing almost anything.  
 3 I am too tired to do anything.
- 18 0 My appetite is no worse than usual.  
 1 My appetite is not as good as it used to be.  
 2 My appetite is much worse not.  
 3 I have no appetite at all anymore.

- 19 0 I haven't lost much weight, if any lately.  
 1 I have lost more than 5 pounds.  
 2 I have lost more than 10 pounds.  
 3 I have lost more than 15 pounds.
- 20 0 I am no more worried about my health than usual.  
 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.  
 2 I am very worried about physical problems and it's hard to think of much else.  
 3 I am so worried about my physical problems that I cannot think about anything else.
- 21 0 I have not noticed any recent change in my interest in sex.  
 1 I am less interested in sex than I used to be.  
 2 I am much less interested in sex now.  
 3 I have lost interest in sex completely.

\_\_\_\_\_ Subtotal Page 3

\_\_\_\_\_ Subtotal Page 2

\_\_\_\_\_ Subtotal Page 1

\_\_\_\_\_ Total Score

APPENDIX D  
Coopersmith Self-Esteem Inventory

## Instructions:

If a statement describes how you usually feel, put an X in the column "Like Me." If a statement does not describe how you usually feel, put an X in the column "Unlike Me." There are no right or wrong answers. Begin at question number 1 and mark all 25 statements.

Like	Unlike
Me	Me

- |       |       |   |
|-------|-------|---|
| _____ | _____ | 1. Things usually don't bother me.                                  |
| _____ | _____ | 2. I find it very hard to talk in front of a group.                 |
| _____ | _____ | 3. There are lots of things I would change about myself if I could. |
| _____ | _____ | 4. I can make up my mind without too much trouble.                  |
| _____ | _____ | 5. I'm a lot of fun to be with.                                     |
| _____ | _____ | 6. I get upset easily at home.                                      |
| _____ | _____ | 7. It takes me a long time to get used to anything new.             |
| _____ | _____ | 8. I'm popular with persons my own age.                             |
| _____ | _____ | 9. My family usually considers my feelings.                         |
| _____ | _____ | 10. I give in very easily.  |
| _____ | _____ | 11. My family expects too much of me.                               |
| _____ | _____ | 12. It's pretty tough to be me.                                     |
| _____ | _____ | 13. Things are all mixed up in my life.                             |
| _____ | _____ | 14. People usually follow my ideas.                                 |
| _____ | _____ | 15. I have a low opinion of myself.                                 |
| _____ | _____ | 16. There are many times when I would like to leave home.           |
| _____ | _____ | 17. I often feel upset with my work.                                |
| _____ | _____ | 18. I'm not as nice looking as most people.                         |
| _____ | _____ | 19. If I have something to say, I usually say it.                   |
| _____ | _____ | 20. My family understands me.                                       |
| _____ | _____ | 21. Most people are better liked than I am.                         |
| _____ | _____ | 22. I usually feel as if my family is pushing me.                   |
| _____ | _____ | 23. I often get discouraged with what I am doing.                   |
| _____ | _____ | 24. I often wish I were someone else.                               |
| _____ | _____ | 25. I can't be depended on.   |



APPENDIX E  
Demographic Questionnaire

Please answer the following questions. For multiple choice items, please circle the letter of the appropriate response. For the remaining questions, please write your answers in the space provided.

1. Age: \_\_\_\_\_
2. Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female
3. Race:
  - a. Caucasian
  - b. African American
  - c. Asian
  - d. American Indian/Native American
  - e. Hispanic/Chicano—Latino
  - f. Other: \_\_\_\_\_
4. Relationship status:
  - a. Single
  - b. Married/Partnered
  - c. Separated/Divorced
  - d. Widowed
  - e. Cohabiting
  - f. Other: \_\_\_\_\_
5. Socioeconomic status
  - a. Upper class
  - b. Middle class
  - c. Working class/Lower class
6. How would you rate the overall quality of your parents' relationship while you were growing up?
 

1	2	3	4	5
excellent	above average	average	below average	poor
7. Are your parents separated/divorced?
  - a. Yes
  - b. No

If Yes, how old were you when they separated? \_\_\_\_\_
8. Is/Was your father an alcoholic?
  - a. Yes
  - b. No
  - c. Maybe

If Yes or Maybe, how old were you when your father developed a drinking problem? \_\_\_\_\_ Also, is your father in recovery?

  - a. Yes      If Yes, how long has he been in recovery? \_\_\_\_\_
  - b. No

9. Is/Was your mother an alcoholic?

- a. Yes
- b. No
- c. Maybe

If Yes or Maybe, how old were you when your mother developed a drinking problem? \_\_\_\_\_ Also, is your mother in recovery?

- a. Yes      If Yes, how long has she been in recovery? \_\_\_\_\_
- b. No

10. Do you have a sibling who is/was an alcoholic?

- a. Yes
- b. No
- c. Maybe

If Yes or Maybe, how old were you when your sibling developed a drinking problem? \_\_\_\_\_ Also, is your sibling in recovery?

- a. Yes      If Yes, how long has he/she been in recovery? \_\_\_\_\_
- b. No

11. Have you ever seen a therapist?

- a. Yes
- b. No

If Yes, did you discuss problems caused by your parent's drinking?

- a. Yes
- b. No

12. Have you ever attended Alateen, Al-Anon, or Adult Children of Alcoholics meetings?

- a. Yes
- b. No

13. On the average, how often do you drink alcohol during a typical month?
- a. Never
  - b. Never, because I am a recovering alcoholic
  - c. Once a month
  - d. 2 to 3 times per month
  - e. 1 to 2 times per week
  - f. 3 to 4 times per week
  - g. nearly every day
14. When you drink, what is the average quantity of alcohol that you consume?
- a. 1 to 2 drinks/beers
  - b. 3 to 4 drinks/beers
  - c. 5 to 6 drinks/beers
  - d. 7 to 8 drinks/beers
  - e. 9 or more drinks/beers
  - f. I don't drink
15. While you were growing up, were you ever subjected to physical abuse?
- a. Yes      If so, from whom? \_\_\_\_\_
  - b. No
16. While growing up, did you ever witness physical abuse between your parents?
- a. Yes
  - b. No
17. While you were growing up, how often did your father drink alcohol?
- a. Never
  - b. 1 to 5 times a year
  - c. 6 to 11 times a year
  - c. Once a month
  - d. 2 to 3 times per month
  - e. 1 to 2 times per week
  - f. 3 to 4 times per week
  - g. Nearly every day

18. While you were growing up, how often did your mother drink alcohol?
- a. Never
  - b. 1 to 5 times a year
  - c. 6 to 11 times a year
  - c. Once a month
  - d. 2 to 3 times per month
  - e. 1 to 2 times per week
  - f. 3 to 4 times per week
  - g. Nearly every day
19. While you were growing up, where did your father do the majority of his drinking?
- a. At home
  - b. Away from home
  - c. Both at home and away from home
  - d. My father didn't drink
20. While you were growing up, where did your mother do the majority of her drinking?
- a. At home
  - b. Away from home
  - c. Both at home and away from home
  - d. My mother didn't drink
21. While you were growing up, how would you describe your father's behavior when he had been drinking? Circle as many as apply.
- a. Verbally Belligerent
  - b. Offensive/Embarrassing
  - c. Abusive— Physically/Verbally
  - d. Passive
  - e. Carefree
  - f. Other \_\_\_\_\_
  - g. My father didn't drink

22. While you were growing up, how would you describe your mother's behavior when she had been drinking? Circle as many as apply.

- a. Verbally Belligerent
- b. Offensive/Embarrassing
- c. Abusive— Physically/Verbally
- d. Passive
- e. Carefree
- f. Other \_\_\_\_\_
- g. My mother didn't drink

23. How significantly do you feel that you have been affected by your father's drinking?

1	2	3	4	5
extremely affected	strongly affected	somewhat affected	slightly affected	not at all affected

24. How significantly do you feel that you have been affected by your mother's drinking?

1	2	3	4	5
extremely affected	strongly affected	somewhat affected	slightly affected	not at all affected

APPENDIX F  
Instructions to Participants

### Instructions to participants

All of your responses to the questionnaires are anonymous and confidential. Please do not put your name on any of the questionnaires. You will notice that a number is written in the corner of each questionnaire. This is to make sure that each participant's answers are kept together — it is not for identification purposes.

IMPORTANT — please read the instructions at the top of each questionnaire. This study should take approximately 30-50 minutes of your time. Your responses are strictly confidential; the informed consent form will be separated from the rest of the materials.



APPENDIX G  
Debriefing Statement

## Debriefing

The study you just participated in was designed to investigate the relationship between growing up in a dysfunctional family and/or with an alcoholic parent and levels of depression and self-esteem.

While some researchers have found adult children of alcoholics (ACAs) to have higher levels of depression and lower self-esteem (among other problems) compared to adult children of nonalcoholics (nonACAs), other researchers have not found this to be the case. In addition, clinicians have observed that adults from dysfunctional families, with no history of parental alcoholism, exhibit some of the same problems that ACAs do. This calls into question whether the parental alcoholism itself causes problems in ACAs or whether it is the level of dysfunction in the family that causes problems.

The purpose of this study is to examine this question by assessing whether ACAs have specific characteristics or problems (i.e., depression and low self-esteem) directly related to parental alcoholism or whether they are simply a subset of a larger group of adult children from dysfunctional families.

It is possible that answering questions about yourself and your family may have brought up many emotions in you or cued some unpleasant memories that you have tried to forget. If you feel the need to talk this over with someone, please contact one of the following resource agencies:

The Drake University Counseling Center  
8 Morehouse Hall  
271-3864

Iowa Lutheran Hospital  
University Ave. at Penn  
Des Moines, IA 50316  
263-5184

Adult Children of Alcoholics  
P.O. Box 1921  
Des Moines, IA 50306-1921  
262-7449

Thank you for participating in this study.

## (DMACC) Debriefing

The study you just participated in was designed to investigate the relationship between growing up in a dysfunctional family and/or with an alcoholic parent and levels of depression and self-esteem.

While some researchers have found adult children of alcoholics (ACAs) to have higher levels of depression and lower self-esteem (among other problems) compared to adult children of nonalcoholics (nonACAs), other researchers have not found this to be the case. In addition, clinicians have observed that adults from dysfunctional families, with no history of parental alcoholism, exhibit some of the same problems that ACAs do. This calls into question whether the parental alcoholism itself causes problems in ACAs or whether it is the level of dysfunction in the family that causes problems.

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It is possible that answering questions about yourself and your family may have brought up many emotions in you or cued some unpleasant memories that you have tried to forget. If you feel the need to talk this over with someone, please contact one of the following resource agencies:

Adult Children of Alcoholics  
P.O. Box 1921  
Des Moines, IA 50306-1921  
262-7449

DMACC Counseling Center  
Ankeny Campus—Building 1  
964-6246

Thank you for participating in this study.

APPENDIX H  
Informed Consent

### Informed Consent Form

The purpose of this study is to investigate the influence of family functioning on perceptions of self. If you decide to participate, you are asked to fill out several questionnaires assessing parental drinking behavior, and attitudes, perceptions and beliefs about yourself and your family. These questionnaires should take approximately 30-50 minutes to complete.

You are in no way obligated to participate in this study. Should you decide to withdraw from this study, you may freely do so at any time without penalty and you will still receive extra credit. At the end of this study, please feel free to ask any questions you may have or you may call Sue Christensen 271-3136.

By signing this form, you voluntarily agree to participate in this project. You can withdraw from the project at any time. You can decline to participate in any part of it or decline to answer any questions without prejudice. Any information obtained from you during the course of your participation will remain confidential and will be used solely for scientific purposes. You may keep a copy of the consent form, if you would like one.

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Name (please print)

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Name (signature)

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Date

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ID Number

If you wish to receive the results of this study, please leave your name and address.